Maternal and Child Health Services
Title V Block Grant

State Narrative for Arkansas

Application for 2010
Annual Report for 2008

Document Generation Date: Monday, September 28, 2009

Table of Contents

I. General Requirements

A. Letter of Transmittal

The Letter of Transmittal is to be provided as an attachment to this section.
An attachment is included in this section.

B. Face Sheet

The Face Sheet (Form SF424) is submitted when it is submitted electronically in HRSA EHB. No hard copy is sent.

C. Assurances and Certifications

All assurances and certifications are kept on file in the Center for Health Advancement, located in the Arkansas Department of Health in Little Rock.

An attachment is included in this section.

D. Table of Contents

This report follows the outline of the Table of Contents provided in the "GUIDANCE AND FORMS FOR THE TITLE V APPLICATION/ANNUAL REPORT," OMB NO: 0915-0172; published March 2009; expires March 31, 2012.

E. Public Input

In accordance with the Guidance for the 2009 Title V Maternal and Child Health Block Grant Application, the first of two public hearings was held Friday, July 11, 2008 at the Arkansas Department of Health. A notice was placed in the Arkansas Democrat Gazette-Northwest and the Arkansas Democrat Gazette-Little Rock for seven consecutive days starting, Friday, June 6 and ending on Thursday, June 12. Seven (7) people (all of whom were Department of Health or Department of Human Services staff) attended, with Dr. Richard Nugent conducting the hearing. He opened the floor for comments, but none was offered.

Although there were no public comments during the public hearing, we will continue to welcome comments from the parent/advisory group for CSHCN, as well as other groups with input regarding the served population after the MCH Block Grant Review in August, at which time copies of this document will be shared and discussed.

/2010/ As prescibed by the Federal Government as part of the application process, the first of two Public Hearings for the 2010 Title V Maternal and Child Health Block Grant application took place on July 1, 2009. The hearing took place at the Arkansas Department of Health Auditorium in Little Rock, Arkansas. A notice was placed in the Arkansas Democrat Gazette-Northwest and the Arkansas Democrat Gazette-Little Rock for seven consecutive days, one month previous to the hearing. Seven (7) people (all of whom were Department of Health staff) attended, with Dr. Bob West conducting the hearing. He opened the floor for comments, but none was offered.

Although there were no public comments during the public hearing, we will continue to welcome comments from the parent/advisory group for CSHCN, as well as other groups with input regarding the served population after the MCH Block Grant Review in August, at which time copies of this document will be shared and discussed.
//2010//

II. Needs Assessment

In application year 2010, it is recommended that only Section IIC be provided outlining updates to the Needs Assessment if any updates occurred.

C. Needs Assessment Summary

/2008/ The needs assessment conducted this year consisted of a review of all measures tracked for the MCH Block Grant, and a presentation to the Center for Health Advancement and to State Health Officer, Dr. Paul Halverson. Comments on the progress of the MCH effort were entertained. A review of all those measures was submitted as expressed throughout this application and annual report. //2008//

/2010/ The needs assessment for this fifth year application was conducted in the same fashion as 2009 and 2008. //2010//

/2009/ Arkansas is preparing for the needs assessment required by the MCHBG Cycle beginning with the application due July, 2010. Early in 2008 the Family Health Branch coordinated a strategic planning conversation with all other Branches in the Center for Health Advancement. These include Chronic Disease, Oral Health, Tobacco Prevention and Cessation, WIC, and a cross-cutting Branch called Life Stages. A preliminary discussion of priorities that are of interest to all the Center's Branches was held. //2009//

/2010/ As strategic planning has unfolded in Arkansas, the efforts can be described by the MCH BG population subgroups: Pregnancy and Infant Services, the Child Health System of Services, Children with Special Health Care Needs and (as added in Arkansas) Women's Health Services. Activities under way in each of these areas are described below.

1. Pregnancy and Infant Health: In early 2008, ADH held an agency-wide planning retreat, developing a Strategic Map addressing the priorities of injury prevention (a trauma system), reducing infant mortality, improving oral health, and enhancing physical activity. The 2009 General Assembly passed increases in the tobacco tax producing major funding for the trauma system and additional support for infant mortality. ADH Executive Staff have held extensive discussions of the Agency's priority for Reducing Infant Mortality (IM). Dr. Nugent has been drafting a White Paper on Reducing IM. Because ADH articulated IM as a strategic priority, and Governor Beebe expressed interest in it as part of the ADH plan, much discussion occurred prior to and during the 2009 session of the General Assembly. Many proposals for actions to reduce infant mortality were prepared and discussed including: a) a statewide effort to re-implement the Olds-Model Family Nurse Partnership, b) a community based effort including outreach and care coordination, c) a three-county project to reduce several health disparities (led by Dr. Thomas Bruce), d) a variety of approaches using social marketing techniques and community-based outreach, and e) a renewed effort at infant mortality review. The Governor and ADH were able to obtain Legislative support and funding at the level of $300,000 (annual and continuing) for infant death reviews, with emphasis on infant autopsies. As part of this discussion, ADH is developing strategic plans for many program expansions related to the Strategic Map. Goals and measurable objectives have been drafted in the area of infant mortality, meanwhile the Governor's interest has stimulated much discussion among many infant-oriented partnerships. ADH, its Center for Health Advancement and Family Health are all deeply enmeshed in "networking the networks" of folks interested in this topic. A group of Executive Staff leaders and Mr. Planey from Family Health visited Mississippi to review its initiative to follow mothers who delivered babies weighing under 1500 grams (Dr. Alfred

Brann). Arkansas has not yet reached consensus on the interventions that will be pursued to reduce infant mortality.

2. The System of Child Health Services: Working over the last year or so, the Arkansas Children's Hospital has financed and led a wide-ranging needs assessment for children's services needs. The results of that process are published in Natural Wonders, the State of Children's Health in Arkansas, 2nd Edition, 2008 (available on request). Arkansas Advocates for Children and Families (AACF), a statewide advocacy organization for children, published the original Natural Wonders Statistical Report comparing Arkansas to the US and other states. The public was engaged through four efforts. First, in the fall of 2007 AACF conducted a phone survey of 2000 households. Second, AACF, with the Arkansas School Board Association, conducted a Study Circles project with 5 community groups throughout the state. Third, the Arkansas Center for Health Improvement, with the state chapter of the American Academy of Pediatrics conducted provider focus groups. Fourth, the UAMS College of Public Health completed key informant interviews with academicians who specialized in content areas relating to children's health. The results of these four efforts are detailed in the Second Edition, 2008 publication mentioned above.

3. Services for Children with Special Health Care Needs: The Title V CSHCN Program will work with the DD Network to hold joint public forums at several sites around Arkansas. The DD Network includes Arkansas' LEND (Leadership Education in Neurodevelopmental Disabilities and Autism) program, Arkansas Disability Coalition and the Office of Disability Rights. Members of the Parent Advisory Council have pledged to assist us in this process as well. Scheduling of the public forums will be done with both daytime and evening sessions to allow increased family participation. We will also target professional groups to garner their opinions as well, either in attendance at public forums or by a targeted survey. The LEND program has pledged to utilize their students for the 09 -- 10 school year to assist with the process of public forums, mail surveys and/or web surveys in areas such as group discussion facilitation, development of meaningful survey questions and analysis of information received from all sources. An evidence-based review of identified needs will be required to assist in targeting issues for discussion at the program level. Strategic planning will then begin to allow program leaders to make final decisions on what areas of need will be targeted during the next 5 year Block Grant process.

4. Services to improve Women's Health: Coordinated by the Dallas Regional Office of HRSA, representatives from all HRSA-funded programs in the state gathered in the fall of 2008 to discuss common interests and priorities. That group reached a consensus around addressing Women's Health in general. HRSA Regional Office Staff documented the results of that discussion (attached). Another major planning effort occurred called the Women's Health Summit, led by Ms. Sandra Brown of Baptist Health in Arkansas. Those recommendations were also published (attached). These two efforts followed a statewide public awareness conference sponsored by Black Entertainment Television (BET) emphasizing women's health with particular attention to nutrition, physical activity, chronic disease management, and teen pregnancy prevention. Over 800 women from around the state attended, as invited through many networks, chief among them being churches.//2010//

III. State Overview

A. Overview

1. The broader health delivery system

The entire Arkansas state population, about 2.8 million people, resides in a region of 75 counties. The city of Little Rock, the state's largest, is situated approximately in the middle of the state, and is the site for 6 large hospitals, the University of Arkansas for Medical Sciences (the medical school), the Department of Health, the Department of Human Services, and other state agencies relating to the health of children. Cities of moderate size are located in the corners of the state, including Fayetteville and Fort Smith in the northwest, Jonesboro in the northeast, Hot Springs in the Midwest, Texarkana in the southwest, El Dorado in the mid south, and Pine Bluff in the Delta Region of the Mississippi River. These cities provide the population base for sizable medical communities and are the locations of Area Health Education Centers (AHECs). Over the state as a whole, the number of physician practices is barely adequate to provide the necessary medical services, but in certain underserved areas, physician and other health provider shortages are common. UAMS, based in Little Rock, provides a centralized point of referral for all medically complicated patients, and also provides medical and health education for the entire state. Except for the communities of West Memphis and perhaps Helena on the eastern border of the state who depend on the city of Memphis in Tennessee, all state communities relate to UAMS and Little Rock Hospitals as the major source of highly specialized medical care. The AHECs provide Family Medicine residency training in communities around the state, and have been of great assistance in improving the distribution of primary care physicians to the corners of the state. By far the most numerous specialty in Arkansas, Family Physicians provide most of the state's medical care. Specialists in obstetrics, pediatrics, internal medicine, surgery and others have practices in the more urban communities. While Arkansas is geographically of modest size compared to some other states, the distances from cities such as Fayetteville and Texarkana to Little Rock require two and one-half to four hours of travel time. For families with few resources, these distances represent significant barriers in access to highly specialized care.

/2010/Fayetteville, located across the Ozarks from Little Rock, is now being developed as a site for a new UAMS campus extension for health care.//2010//

2. The system of state agencies providing support to the health system for women and children

The Arkansas General Assembly in its 2005 session passed legislation formally merging the Department of Health and the Department of Human Services into a new Department of Health and Human Services.

/2008/ The Arkansas General Assembly, in its 2007 session, passed legislation allowing the Governor to "de-merge" the Department of Health and Human Services into its Department of Health and Department of Human Services components. As of July 1, 2007, the Arkansas Department of Health (ADH) and the Arkansas Department of Human Services (DHS) were again separate, cabinet-level agencies. A new table of organization is attached. Much of the description of the previous organizational structure presented in earlier versions of this Title V application has been removed in the interests of brevity and clarity. //2008//

/2009/ The new structure of the ADH has now become well established. Leadership in all the newly reworked administrative offices has been hired and is gaining experience. Dr. Halverson has recently conducted a subsequent strategic planning process. Guided by a nationally experienced facilitator, the ADH Executive Team and Senior Staff, including Dr. Joseph Thompson, the Arkansas Surgeon General, developed a Strategic Map. A copy of that map is attached. The Overall Goal of the ADH is To Improve Health and Reduce Disparities. Under that goal there are five Priority Areas:

- Strengthen Core Services -- (Family Planning, Prenatal Care, Immunizations, WIC, Home Health, etc) by quality assessment, recommendations for improvement, implementation of those recommendations and re-evaluation.
- Develop more Effective Population-Based Approaches -- (Injury prevention and control, Reduce infant mortality, Increase physical activity, and Improve Oral Health).
- Communicate Public Health Value and Societal Contribution -- (Economic development, Public awareness, Benefits of prevention).
- Secure Adequate Human and Financial Resources -- (Workforce needs, Workforce training, gaps, funding acquisition).
- Increase Departmental Effectiveness and Accountability -- (Strengthen leadership, management systems, IT infrastructure, data utilization, accountability).

Cross-cutting all these areas are emphases on community engagement, partnerships, and policy development. //2009//

/2009/ The overall theme is to strengthen and improve traditional public health clinical services; and, at the same time, focus on several specific program developments, engage more in public awareness and policy developments, and retool administrative processes to work more effectively and efficiently.//2009//

/2010/ Arkansas continues to pursue the priorities of the "Strategic Map" mentioned in the note for 2009 above. With the close of the 2009 session, the Arkansas General Assembly passed a 56-cent per pack cigarette tax, and added taxes on other tobacco products. This new funding will enhance a variety of health program expansions including a new trauma system, increasing Medicaid eligibility in AR Kids A and B programs to 250% of poverty, and offering a small amount of new funding for infant mortality.//2010//

/2008/ The CSHCN Program, in the structure after July 1, 2007, will remain in the Division of Developmental Disabilities Services now located in the Department of Human Services (DHS). //2008//

/2008/ The ADH (beyond July 1, 2007) prioritizes health services according to the strategic planning process already established by State Health Officer, Dr. Paul Halverson, including internal and external phases. 1) ADH continues to provide the highest priority services in all counties. Highest priority services include Immunization, Family Planning, WIC, STI, infectious disease outbreak management, Breast and Cervical Cancer Control, and environmental health. In the past, well child clinics fell into this category, but with Medicaid assignment of EPSDT children to primary care physicians in the private sector, these clinics were discontinued by the Department of Health. Other highest priority services have traditionally been provided not in the local clinics, but through the Central Office. These include Newborn Metabolic and Hearing screening, and collaborations with Medicaid to assure enrollment in Medicaid and appointments with primary care physicians. These highest priorities continue. 2) Second priority services include basic preventive services for which availability is necessary in all counties, but for which local health systems may not have sufficient capacity. These include maternity care, and home health services. 3) The remaining priorities include those preventive services that are optional for counties such as services for patients with diabetes and hypertension. //2008//

/2008/Over the past several years, the Department of Health has been developing request for proposal programs to fund competitive special projects in selected counties. Services provided through these resources included Abstinence Education, Unwed Birth Prevention, and Smoking Cessation.//2008//

/2008/ The state of Arkansas will now manage the Title V program in the two separate Departments. The Maternal and Child Health services will now be managed in the Arkansas Department of Health (ADH), and the Children with Special Health Care Needs services are managed in the Department of Human Services (DHS).

That arrangement provides the administrative context for maternity and preventive children's services to be conducted in Local Health Unit clinics throughout the state, and for Children with Special Health Care Needs services to be managed in close relationship with the DHS Divisions of Developmental Disabilities, Children and Family Services, and Medicaid. CSHCN services are closely associated with specialty services of the Department of Pediatrics at UAMS. //2008//

/2008/ Many remarkable earlier changes in these services had occurred in Arkansas, preceding the 2005 merger and 2007 de-merger of the two state agencies. For example, the Medicaid Program reorganized the EPSDT Program to create the AR Kids First Program. Medicaid assigned all EPSDT enrolled children to primary care physicians (largely private doctors) and ADH discontinued providing EPSDT screenings. At the same time, the new AR Kids First Program raised income eligibility for children of low-income families to 200% of poverty. The federal State Child Health Insurance Program (SCHIP) funds enabled an increase in eligibility from 185% (133% or 100% depending on age) to 200% of poverty for children up to 18. As a result the number of children in low-income families who were not covered declined. With a reduction in need, and without reimbursement, the ADH discontinued its well child clinics. ADH still provides services for children including immunization, injury prevention, newborn metabolic screening, newborn hearing screening and other prevention programs for children including SIDS. ADH uses the 30% of MCH Block Grant funds required to support health services for children to enhance immunization programs and maintain preventive and population-based services for children. Especially, ADH uses children's health systems funding to enhance its collaborative efforts with DHS Divisions and the Arkansas Department of Education (ADE) for such initiatives as Early Childhood Education, Coordinated School Health, and the Sytem of Care for Child Mental Health.//2008//

/2008/Dr. Paul Halverson will remain as the Director of the ADH, and Dr. Joseph Thompson will remain as the chief medical adviser to the Governor (now called the state's "Surgeon General"). Both are cabinet positions and are active in the deliberations of the Board of Health, though the Surgeon General does not have a vote, and the Director may not serve as chair. The 2007 General Assembly also provided that the duties and responsibilities of the State Board of Health be brought to the ADH largely intact. The leadership of ADH will retain the structure of its Executive Staff, and the Centers, including Local Public Health, Health Advancement, Health Protection, Health Practice, and the State Laboratory. Externally, links to communities remain strengthened through continuation of the Hometown Health Initiative staff in ADH. Mr. John Selig will remain as Director of Human Services, and his commitment to interagency cooperation continues.//2008//

/2008/ Links between health-related organizations in state government and the University of Arkansas for Medical Science are remarkably stronger with the development of the College of Public Health. Links with the professional boards of Medicine, Nursing, and other disciplines remain strong. The new Department of Health will continue with its responsibilities to license hospitals in the state, and to relate closely with the Hospital Association. Other disciplines such as dentistry, pharmacy and chiropractic continue their representation on the Board of Health, along with medicine, nursing and hospitals.//2008//

/2008/ As presented above, environmental services and clinical services that are preventive in nature and represent "gap-filling" activities will continue in the 94 local health units in 75 counties. Local services are supported by a system of Franchise Agreements (FAs). FAs set out the requirements for service delivery conducted in communities as led by five Regional Teams. In addition to Franchise Agreements, the ADH makes special grants to local community lead agencies for special program interventions. These local projects include tobacco control, chronic disease, oral health, family planning outreach, and services to the developmentally disabled. However, a great deal of programmatic support is provided to regional leadership and technical assistance through the School Cooperatives that house the Community Health Nurse Specialists (CHNS) and the Community Health Program Specialists (CHPS). These offices link the program resources of tobacco control, chronic disease, and maternal and child health to assist

schools.//2008

Arkansas's population stood at 2.7 million people as of 2004. Among states, Arkansas has high proportions of rural, low income and minority citizens. A very broad range of health measures in this state rank unfavorably compared to other states. These include many of the data trends captured in the MCH Block Grant performance measures. Arkansas' five health regions are diverse in geography and demography. The Central Region around Little Rock is relatively urban and well supplied with available health services for women and children. However, even in these counties low-income families experience barriers in access to care. All other regions are rural and poor and many are medically underserved as defined by HRSA programs. Counties along the eastern border of Arkansas, the Mississippi Delta are especially rural and poor and have high concentrations of minority populations, especially African American. Counties along the western border are mountainous and rural. They have fewer minorities, but are high impact for immigrant Hispanic families from Central and South America. A group of Marshallese families live in the far northwestern counties and experience outbreaks of infectious diseases including STIs, TB and Hansen's Disease. Counties along the southern border of the state are also rural and poor, depending on farming and timber as their predominant source of income.

/2008/ As the task of "de-merging" the Department of Human Services (DHS) and the Department of Health (ADH) proceeds, any impact on Maternal and Child Health (MCH) and Children with Special Health Care Needs (CSHCN) programs will become evident, but we do not anticipate a great deal of change. The transfer of the Title V CSHCN program within DHS from the Division of Medical Services (DMS-the division that includes the state's Medicaid program) to the Division of Developmental Disabilities Services (DDS) has been successful. In DDS, the Title V CSHCN program has found a mutual family friendly "spirit". //2008//

/2008/ While the DDS Children's Services reorganization continues, the CSHCN program will need to be an articulate advocate for maintaining and even developing both reimbursement programs for special needs children and important enabling services such as care coordination and transitional care. //2008//

/2007/ As of June, 2006, internal reorganization of the Division of Health has made much progress. Dr. Halverson, as Director, is aided by Dr. Joseph Bates, the Deputy Director for Science, Mr. Charles McGrew, MPH as the newly appointed Deputy Director and Chief Operating Officer, and Mr. Michael Wolff as Deputy Director, who brings a wealth of administrative experience from private sector health organizations. Mr. Randy Lee, RN, has been appointed as Director of the Center for Local Public Health, and Mr. Stephen Boedigheimer, MBA remains as CDC Senior Management Official, our liaison officer to CDC. Mr. Boedigheimer's chief responsibility is to manage the "CDC Portfolio of programs" conducted by the Arkansas Division of Health. Newly directed by Dr. Jennifer Dillaha, the Center for Health Advancement now houses the Family Health Branch (managing the MCH Block Grant), as well as Branches for Chronic Disease, WIC, Oral Health, and Life Stages. The Life Stages Branch is "cross-cutting." It houses offices for Children in Schools, Adults in the Workplace, and the Elderly in Communities. It also houses experts in Nutrition, Physical Activity, and Tobacco Cessation. //2007//

/2007/ The four recently established Centers within the Division are taking form. In the Center for Local Public Health, now directed by Mr. Lee, Mr. Rick Sanders serves as Associate Director for Management and Operations, Mr. Lee's former role. Dr. Richard Nugent serves as Associate Director for Science, Ms. Aurian Zoldessy as State Patient Care Director, Bill Rodgers as Rural Health and Primary Care Director, and Neldia Preston as State Quality Improvement Leader. The Offices of the five Health Regions are managed in this Center, as are the Branch Offices of Environmental Health, Field Support Services, and In-Home Services (Home Health). //2007//

/2007/ The Center for Health Protection is directed by Mr. Donnie Smith, and Dr. William Mason serves as Associate Director for Science. Mr. Ron Stark serves as Associate Director for

Management and Operations. That Center's Branches include Health Systems Licensing and Regulation, Infectious Disease, Preparedness and Emergency Response, and Injury Prevention and Control. //2007//

/2007/ The Center for Public Health Practice is Directed by Martha Phillips, PhD, MPH, MBA, an epidemiologist, Ms. Michelle Priebe as Associate Director for Management and Operations, and Dr. Frank Wilson as Associate Director for Science. The Branches in that Center include Health Statistics, Epidemiology, Workforce and Career Development, and Health Marketing. //2007//

/2007/ The fifth Center is the State Laboratory, Directed by Dr. Glen Baker. Mr. Ed Just serves as Associate Director for Management and Operations. The Center's Branches include Clinical, Biological, Chemical, and Alcohol Testing. //2007//

/2007/ The Center for Health Advancement (CHA), in which the MCH Program is administered, is Directed by Dr. Jennifer Dillaha. Ms. Maria Jones serves as the Associate Director for Management and Operations, Dr. Namvar Zohoori as Associate Director for Science, Ms. Jane Costello as Director for Quality Improvement, and Ms. Marilyn Dunavant as Grants Manager. The Branches of the CHA include Chronic Disease, Family Health, Lifestage/Healthy Arkansas, Nutrition and WIC, Oral Health, and Tobacco Prevention and Cessation. //2007//

/2008/ As a Department, ADH will continue to develop the Centers as described above, and will develop its own offices for finance, personnel, information technology, mail room, and other administrative functions. Transitional plans for these changes are in effect (beginning May, 2007) and the offices should be functioning by the fall. The structure of the Centers within the health organization are not anticipated to change, except for the addition of the administrative offices. //2008//

/2008/ Ms. Kaki Roberts has been hired as the Budget Coordinator for the Center for Health Advancement. //2008//

/2007/ The Family Health Branch is headed by Dr. Richard Nugent as Chief, and Ms. Carladder Parham as Associate Chief. It houses the MCH-related Sections of Child and Adolescent Health, Women's Health, and Connect Care. The Connect Care Section is funded largely by a contract from Medicaid, and is the office providing coordinated outreach and education to Medicaid Recipients, assignment to primary care physicians, and assignment to dentists. A major role of this Section is to operate a 24/7 telephone hotline center serving Medicaid, Healthy Arkansas, the Healthier Babies Campaign, and now the implementation of Arkansas's new Clean Air Act. //2007//

/2008/ The ConnectCare Section was re-named "Health Connections" to better reflect the diversity of responsibilities in the Section. The activities encompassed in the Medicaid contract continue to use the moniker "ConnectCare." //2008//

/2008/ Ms. Carladder Parham was promoted to Director for the Central Health Region, and left her position as Associate Chief of Family Health last year. Mr. Bradley Planey was promoted to Associate Chief of Family Health in May, 2007. Mr. Planey formerly served as the Chief of the Women's Health Section within the Branch, and a replacement will be recruited. Ms. Berna Thomas, hired as a grants manager to assist with both the MCH Block Grant and the Title X Grant, has accepted another job in the agency. Her position has been reassigned to the new administrative offices of the ADH in transition. Ms. Li Zheng, the MCH Epidemiologist, resigned and her position has been refilled by Terri Wooten. Terri is a long-time statistician in the Center for Health Statistics, and has been responsible for developing the MCH Block Grant Annual Report for many applications. She is near completion of her MPH Degree in Epidemiology, and already brings great familiarity not only with MCH data, but also MCH programs and planned data analysis for policy development. A new table of organization for the Center and Branch is appended. //2008//

/2010/ Mr. Bradley Planey's job as Chief of the Women's Health Section has been filled with Ms. Sharon Ashcraft, an experienced public health nurse and nurse practitioner. As of June, 2009, Mr. Boedigheimer has been reassigned by CDC, leaving Arkansas. Once a part of the Center for Health Advancement, the Tobacco Prevention and Cessation Branch has been removed from the CHA and placed under the direction of Mr. McGrew as CEO. Close relationships between its Branch Chief, Dr. Carolyn Dresler, its programs, and Family Health Branch programs continue. Intense efforts at tobacco cessation continue for pregnant women.//2010//

B. Agency Capacity

/2009/ The Arkansas Department of Health 's organizational structure is functioning well since being restored as a stand-alone agency in state government on July 1, 2007. A recent strategic mapping discussion at the Executive and Senior Staff level confirms the Department's commitments to maintaining and improving its clinic services in local health units, and its renewed commitments to public awareness and policy development for many health issues.//2009//

/2010/ Over the last year, the Arkansas Department of Health has not yet experienced budget cuts due to the economic recession, but it has experienced increased expenses in saleries that were only partially funded by the legislature. The salery increases were the result of a new pay plan, a new nursing grid and legislated performance incentives. In order to stay within it's budget, the agency cut program activity aimed at teen pregnancy reduction, reductions in second order births for at risk populations and health literacy for pregnant women. //2010//

/2008/ The new Arkansas Department of Health (ADH) will continue to address the health of women and children. July 1, 2007 was its official start date. This health agency returns to its former name and maintains many of the internal organizational relationships begun under Dr. Halverson in the past 2 years. Besides developing administrative offices for finance, personnel, IT and support services, little change at the Center level and above is anticipated. //2008//

Arkansas has a variety of state statutes that guide the provision of services to mothers and children. There is no overall statutory authority for the MCH population, so existing statutes will be discussed within each of the sub-populations.

1. Preventive and Primary Services for Infants and Pregnant Women

Maternity services work to ensure all pregnant women in Arkansas have access to early and continuous prenatal care, thereby reducing the number of preterm and low birth weight infants and lowering infant mortality and maternal morbidity and mortality.

Target Population:Pregnant women in Arkansas, specifically those with no other source of prenatal care.

Description of Services:Maternity clinics provide prenatal services, including risk assessments, laboratory, physical assessments, patient counseling, prenatal education classes, nutrition, social work counseling and referrals for high-risk care. Case management and follow-up ensures patients receive services needed. Medicaid eligibility is determined and, where possible, patients are referred to local physicians for continuance of care. All Local Health Units offer basic pregnancy testing and counseling, and referral to local physicians or to a neighboring Unit giving prenatal care. Working with the ANGELS (Antenatal and Neonatal Guidelines for Education and Learning Systems) program at UAMS, ADH anticipates implementing new screening methods for smoking, depression, partner violence and substance abuse. State law requires that all pregnant women be tested for HIV, unless they have been counseled and have refused the test.

/2008/ All local health units provide pregnancy testing, prenatal counseling, and screening for presumptive Medicaid eligibility. The county health units work with nearby Local Health Units, and other care providers to ensure pregnant women have access to early prenatal care. Clients are provided referral information and accessibility to other ADH services, such as WIC and Immunizations. In 64 sites, located in 57 counties, ADH also provides prenatal clinic care that includes physical assessments, laboratory testing, genetic screening and counseling, prenatal education, nutritional counseling and education, WIC services, and referrals as indicated for high risk care. ADH clinicians and public health nurses work closely with the University of Arkansas's perinatal program, ANGELS (Antetnatal and Neonatal Education Guidelines, Education and Learning System). With significant support from the Arkansas Department of Health and Human Services, ANGELS provides evidence-based guidelines for maternal-fetal and neonatal care. //2008//

/2008/ The Midwifery Licensure program, with ADH legal support and major input from licensees, has majorly rewritten midwifery regulations. Those regulatory changes were adopted in the spring of 2007. We are now preparing an educational program, to be transmitted via the Internet, to train the 32 licensed midwives. New forms for reporting both births attended, and apprentices trained, are being developed, and will also be forwarded as required for administrative review by the state legislature. //2008//

/2009/ Recent regulatory change brought approval of new forms operationalizing the new midwifery rules. //2009//

Support for the Campaign for Healthier Babies is both monetary and in-kind. In-kind support aids responses to requests for coupon books and other information. Monetary assistance helps with planning the Campaign's activities and provider relations efforts.

In addition, the ADH manages a home health program called In Home Services. Part of the care it provides is called the Maternal and Infant Program (MIP). MIP, if requested by a local health unit and ordered by Dr. Nugent, will make home visits to pregnant women at risk. For example, one at-risk group includes pregnant adolescents who would benefit from home assessment and further follow-up. In addition, MIP will visit pregnant women who have medical complications such as pre-ecclampsia requiring bed rest, diabetes requiring insulin therapy, or infants requiring special monitors or IV therapy. (~5000 mother/infant pairs served)

/2010/ Occurance of ADH maternity clinics in counties changes from time to time. This is largely dependent on the Local Health Unit having staff with the right skill sets and time. This is effected by staff turnover, ability to fill positions and the number of renatal patients in small counties. In addition, some counties have local physicians that wish to provide all the prenatal care, regardless of the patient's ability to pay. A county's percentage of births with first trimester prenatal care data is considered in making the decision.//2010//

2. Primary and Preventive Services for Children

The purpose of the Child and Adolescent Health Program is to encourage community-driven public health by promoting safer and healthier communities through education, prevention, and intervention by ensuring that statistically driven initiatives are in place through integrated stewardship.

Target Population:Birth through adults for the State of Arkansas.

Description of Services
Child and Adolescent Health comprises different programs serving the needs of the communities in Arkansas such as Community Smoke Alarm Installation and Education Program, Fire & Fall Prevention of Adults, Core Injury, Violence Prevention/Intervention, Infant Hearing, and Childhood Injury Prevention.

/2007/ The Injury Prevention Services Program was moved to the Center for Health Protection. Funding for infant car seats and the Safe Kids Coordinator position was discontinued with the ending of the Preventive Health Services Block Grant. The following services were transferred to Health Protection from Child and
Adolescent Health:

·Installation of smoke alarms in five hundred households per county;
·Training for senior citizens in fire and fall prevention;
·Establishment of coalitions and focus groups for core injury and violence prevention;
·Collaboration with Hometown Health Improvement Coordinators to identify areas that will benefit from the violence programs;
·Curriculum for various programs listed above. //2007//

The Arkansas Safe Kids Coalition distributes free bicycle helmets to community groups, school groups, health fairs, and bicycle rodeos and provides preventive measures and education for children and caregivers on the importance of using seat belts.

/2007/ State statutes provide the legal basis for infant hearing screening, newborn metabolic screening and hospital licensure (containing hospital standards for services to women and children). 1) The hearing statute establishes that all hospitals delivering over 50 babies a year will conduct physiologic hearing screening on newborns, and will report the results to the ADH. 2) The Laws regarding newborn metabolic screening require birthing hospitals to obtain heel-stick blood specimens from babies, and to submit them to the State Lab. 3) State statutes provide for the licensing and review of hospitals within the state. For each of these laws, the Board of Health has established regulations that are monitored and revised from time to time as needed for the system of care they each guide. In the 2005 legislative session, a change in the newborn screening law established that the Department would conduct, in addition to the nationally "mandated" newborn screens of PKU, Hypothyroid disease, Galactosemia and Sickle Cell disease, "other tests" as provided for in regulation from the Board of Health. This change provided the legal basis for the Board of Health to require the implementation of expanded newborn screening as recommended by the National Foundation, March of Dimes. //2007//

/2008/ The Board of Health has initiated regulatory change to extend newborn metabolic screening to cover the 29 "Core" conditions recommended nationally for all states to implement. The rule change process is now being pursued and should be completed by the winter of 2007. With the Governor's support, and with the passage of the state budget in the 2007 session of the General Assembly, Arkansas provided positions and appropriation to recruit new staff for the Lab and the Follow-up programs. On July 1, 2007, ADH started recruiting for the extended staff for the Laboratory and the Follow-up Programs. ADH anticipates that a full year of program development will be needed to hire and train staff, obtain special laboratory equipment, run a pilot study of Arkansas children to set "cut points" for lab readings, develop follow-up and referral protocols, and carry out professional education and public awareness efforts. //2008//

/2010/ On July 1, 2008, the ADH initiated expanded NBS screening covering all 29 nationally recommended conditions. As of May 30, 2009, the ADH Lab tested all specimens submitted since July 1 for all 28 metabolic conditions. Among those specimens, positive tests for anticipatably common conditions (MCAD and Cystic Fibrosis) have been identified. It is not apparent that any cases have been missed. //2010//

Target Population:The Abstinence Education Program supports education for youth and young adults, 12 to 29 y.

The AEP awards subgrants to local communities to support abstinence education initiatives. Some grants are funded by the MCH Bureau, through the ADH. Those grants require match of three non-federal dollars for every four federal dollars awarded. Match requirements are

achieved with in-kind donations from local communities. Each sub grantee is required to maintain records of clients served, develop a quarterly narrative progress report and track and monitor program activities. In previous years, AEP required sub grantees to work with the state evaluator. The evaluation determines the program effectiveness by self-report of student knowledge and behavior regarding sexual health values and practices. A Final Report was anticipated fall, 2008. Technical assistance workshops provide knowledge and training of grant requirements to sub grantees. Site visits (monitoring) are performed to assure the quality of the data collected and to view abstinence interventions in the local communities.

/2008/ Federal funding for the AEP through Title V and other sources, as of this writing (June, 2007) is being heavily questioned because of a relatively rigorous Mathematica evaluation in a number of communities of differing demographics, showing no change in behavior despite adequate "dosage" of instruction and contact. In fact, communications from the funding federal agency prohibit incurring any costs against the Title V program after June 30, 2007. Planned renewals of competitive community grants is on hold until future funding is assured. In early July Congress approved funding through September 30th, but the President has yet to sign the bill. //2008//

/2009/ The assuredness of funding for Abstinence Education continued to decline and the number of funded projects also declined. Congressional and national agency determinations to continue the program have been late and uncertain.//2009//

/2010/ Currently, the Arkansas Abstinence Education Program funds six community-based projects. The funding for the federal Title V Abstinence Education Program will end June 30, 2009 unless the program is reauthorized by Congress. //2010//

Grants foster abstinence education (educational or motivational) programs that (1) have as its exclusive purpose, teaching the social, psychological, and health gains to be realized by abstaining from sexual activity; (2) teach abstinence from sexual activity outside marriage as the expected standard for all school-age children; (3) teach that abstinence from sexual activity is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases, and other associated health problems; (4) teach that a mutually faithful monogamous relationship in context of marriage is the expected standard of human sexual activity; (5) teach that sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects; (6) teach that bearing children out-of-wedlock is likely to have harmful consequences for the child, the child's parents, and society; (7) teach young people how to reject sexual advances and how alcohol and drug use increases vulnerability to sexual advances; and (8) teach the importance of attaining self-sufficiency before engaging in sexual activity.

/2008/ The Arkansas Abstinence Education community-based projects, now numbering 10, but having been active in 28 separate locations over the last 5 years, have been actively evaluated by Stan Weed, PhD, a behavioral researcher. At this time, a written interim report is available for review, and Dr. Weed has made a verbal report to the Department regarding his findings. The evaluation methodology includes assessing students by questionnaire before the start of the educational "dose," after the intervention has been carried out, and at 12 months after the close of the intervention. A review of the data from these questionnaires reveals improvements in values, beliefs and behaviors at the close of the intervention, but by twelve months after the close of intervention the effect is almost entirely gone. //2008//

/2010/ The Phase V Final Report on the Title V Arkansas Abstinence Education Program, completed by Stan Weed, PhD and submitted November 2008, focused on self-reported initiation and discontinuation rates for sexual activity and further analysis of the maintenance/deterioration effect on the short term measures for the combined years 2005-2006 and 2006-2007. Although the data revealed that program males initiated sex at a significantly lower rate than comparison students, there was not a significant difference between program and comparison females. In the opinion of the evaluator, limitations in

the data set prevented comparison between the two years, and therefore, strong conclusions regarding program effects over time could not be made, as any observed changes could merely reflect differences between the samples from year to year.//2010//

/2010/ Since 2006, the ADH and the Arkansas Department of Education (ADE), Office of Coordinated School Health have partnered to support establishment of Coordinated School Health initiatives (CSH) in Arkansas. In 2006, 9 pilot projects were established. A CSH Coordinator was hired at ADH as a counterpart to a CSH Coordinator at ADE. In 2007, the ADH, Office of Tobacco Prevention and Cessation entered in a collaborative partnership with ADE to provide funding for an additional twenty-three school districts, totaling 31 school districts involved in CSH. Over the next 2 years, 18 school districts will receive funding. //2010//

The Office of Oral Health (OOH) envisions Arkansas as a state where everyone enjoys optimum oral health through primary prevention at the community, healthcare professional and family levels. This can be accomplished through: accessible, comprehensive and culturally-competent community-based oral health care provided through a variety of financing mechanisms; educational opportunities throughout life that will allow individuals to make better decisions for their health; and informed and compassionate policy decisions at all levels of government.

Target Population: Infants, children, adolescents, adults, and the elderly in the State of Arkansas.

Description of Services: OOH colleagues provide education and awareness on a variety of oral health issues including fluorides and fluoridation, dental sealants, infection control, oral cancer, access to care, tobacco cessation and prevention, and family violence prevention. OOH assists communities with water fluoridation through community presentations and providing funding through the Preventive Health and Health Services Block Grant. Working with the Division of Engineering, OOH provides water plant operator trainings throughout the state. Working through the Arkansas Oral Health Coalition, OOH provides dental sealants to at-risk children. OOH colleagues conduct a wide variety of assessment activities throughout the state on children, adolescents and the elderly. Reports on the various assessment activities are available and are combined into an oral health burden document.

/2010/ State legislative activity requiring fluoridation of public water supplies has occurred in G. A. sessions 2005, 2007 and 2009. Legislation requiring fluoridation of water supplies for communities of a certain size has regularly failed passage. //2010//

3. Services for Children with Special Health Care Needs

/2007/ Decrease in staff led to consolidating the caseload of CSHCN, whose specialty health care costs are born solely or in part by the Title V CSHCN program, among 3 RN's. There was no decrease in the number of qualifying applicants & open cases (approximately 600) so the caseloads increased substantially.//2007//

Current active cases include undocumented Hispanic children & youth that do not qualify for Medicaid because of their citizenship status. Since they are not eligible for SSI, the cost of their health care is born by the Title V CSHCN program. Approximately 40% of the applications received for children and youth are approved for payment of a diagnostic evaluation prior to any eligibility determination being made. Many of these individuals are subsequently found to be ineligible for ongoing coverage due to being financially ineligible or diagnostically ineligible. The RNs are able to make referrals for services the family may subsequently need and be quite unaware that the services are available or needed. As funding permits, Title V CSHCN works with families of eligible children and youth covered by Medicaid to fund purchases of equipment that is not covered in the Medicaid state plan (e.g. IPV machines, van lifts & wheelchair ramps) and payment for children and youth with special needs to attend various Med-Camps during the summer. Attendance at these camps allows time for peer interaction and socialization while

teaching diagnosis-specific self-care in a fun camp environment. Title V CSHCN paid for services for approximately 100 children and youth covered by Medicaid for the purchase of equipment/services not covered by Medicaid.//2007//

/2008/ Over the past year, Title V CSHCN has paid for equipment and services for 150 children and youth covered by Medicaid. This ranges from audiology visits, purchase of hearing aids, therapy and orthotics for children covered by the ARKids B program (SCHIP) to purchase of IPV machines for preemies to allow discharge home, wheelchair ramps, van lifts and overhead lifts for the home for children covered by SSI or TEFRA.//2008//

/2007/ Title V staff provide Medicaid-reimbursed care coordination assistance to approximately 3,200 children & youth with special needs & their families. The Medicaid recipient must be medically eligible for the Title V CSHCN program unless the individual is under age 16 and receives SSI or TEFRA benefits. Those recipients receive Title V CSHCN care coordination assistance regardless of whether the diagnosis qualifies them medically for the program. CSHCN staff consists of a Service Specialist, Social Worker or RN trained as a Title V CSHCN care coordinator and a medically trained Secretary who has received training and experience in care coordination. Knowledge of programs and providers of services in the state and local community allows Title V CSHCN staff to make appropriate referrals in a timely manner. Some referrals are for Special Needs Funds and Integrated Supports, DDS programs that provide timely relief to families with emergency needs. Title V CSHCN staff also make referrals and assist with applications for the ACS Home and Community Based Waiver. Approximately 3400 children and youth are served by Title V CSHCN staff for case management assistance.//2007//

/2008/ Approximately 3900 children and youth receive care coordination services from Title V CSHCN staff.//2008//

/2009/ The AR Title V CSHCN program has continued to pay for services not covered by Medicaid. During the past year, 148 Medicaid recipients who qualify for coverage had services paid for by the Title V CSHCN program. The types of services paid for remain the same as previous years except for the purchase of IPV machines. The cost of those machines rose 40% within a few months. In response, the program implemented a new requirement regarding IPV machines. Since most requests come from Arkansas Children's Hospital (ACH), the program required that the ACH Pulmonary Department utilize the existing process that enables providers to request Medicaid coverage of non-State Plan services by providing documentation of medical necessity to Arkansas Medicaid. Now most IPV machines are being paid appropriately by Medicaid as medically necessary and funds have been freed up in the Title V program for other needs.//2009//

/2009/ Approximately 2,180 children and youth receive care coordination services from the Title V CSHCN staff. The decrease from the previous year is due to the removal of Part C Early Intervention job tasks from the majority of CSHCN staff responsibilities. In addition to this change, the program and staff have made a concerted effort to clean up the database by closing duplicate cases and initiating programming changes that created a system-generated process for closure of cases at age 22, if staff had not made the change.//***2010//***

//2010// AR Title V CSHCN paid for services for approximately 800 children and youth during the last reporting period. Twenty-five percent of those are Medicaid beneficiaries for whom a gap in coverage existed. This involved a variety of services including compound drugs, medical supplies, van lifts, wheelchair ramps, PKU Food, and inpatient Rehabilitation Services. Another cohort identified is those covered by Arkansas SCHIP requiring the following services: Audiology services, purchase of hearing aids, Physical Therapy and Occupational Therapy. Our data shows that 72 of those served are undocumented and our program is the primary payer for their specialty care utilizing 19% of the budget. Although the recession has been slower to hit Arkansas, we have seen increases in the number of applications received from families who have been impacted by the loss of jobs or new circumstances of under-employment. Although the

majority of the families with unemployment qualify for Medicaid, many of them qualify only for ARKids B which offers limited services and for CSHCN with certain diagnoses, our program is called upon to supplement those services. /***//2010//***

//2010// The Title V CSHCN program provides care coordination services for approximately 2,100 children and youth. /***//2010//***

/2007/ 766 referrals were received by Title V CSHCN staff for Part C services during FY05.//2007//

/2008/ 1,569 referrals for Part C services were received by Title V CSHCN staff during FY06. A decision has been made by the Division Assistant Director to pull Part C duties from the responsibilities of Title V CSHCN service coordinators & managers & form separate work units. There will be a subsequent shrinkage of service coordinators who are available to perform Title V CSHCN program tasks, but conversely, the removal of Part C referrals & requirements will increase the amount of time the remaining service coordinators have to perform the Title V CSHCN program tasks. //2008//

/2009/ Four of the CSHCN staff were required to continue to work Part C cases until staffing in that unit was increased to assume the caseload. At the current time, two CSHCN staff (an RN and a SW) continue to work Part C cases--the SW on a full time basis and the RN works Part C in addition to providing CSHCN care coordination services.//2009//

/2010/ All Title V CSHCN professional staff have been relieved of care coordination duties related to the Part C Early Intervention program and have returned to work full time in our program.//2010//

/2007/ Active cases in the Alternative Community Services Home & Community-based Waiver program were transferred from CSHCN staff to the Waiver Unit in the Division in May 2006. This allowed us to deploy those staff to serve CSHCN in a case management capacity once again.//2007//

/2008/ Title V CSHCN care coordinators continue to work with families to access services through Developmental Disabilities Services (DDS) programs. The most prominent & time-consuming of these is the Alternative Community Services Home & Community Based Waiver. Other DDS programs include Integrated Supports services (for families in crisis situations who require wrap around services to enable them to keep their children & youth in the community) & Special Needs funding (a process to assist a family to obtain help in the form of respite, purchase of low cost equipment, receive training or assist with rent/utilities). //2008//

/2009/ To provide accurate data to the work unit responsible for eligibility determination for the Alternative Community Services Home and Community Based Waiver (coordinated by the Division of Developmental Disabilities), a system was developed to allow the program to monitor pending applications worked by CSHCN staff until they are determined eligible and placed on the service request list. Since beginning the process on February 19, 2008, the program has received 374 individual referrals. CSHCN staff currently manages 12 Integrated Supports cases on an ongoing basis. During the last state fiscal year, CSHCN staff processed 60 requests for DDS Special Needs funding.//2009//

/2010/ A large portion of Title V CSHCN staff time is spent in working with families during the application process for DDS programs. Our staff has provided information and assistance on approximately 1,000 applications for the ACS Home and Community Based Waiver coordinated by DDS. Of note, approximately two-thirds of the individuals on the waiting list for DDS Waiver services are under 20 years of age and Title V staff are responsible for providing assistance in meeting needs during that time. //2010//

/2007/ The Friends & Family Respite Waiver reapplications were withdrawn by the agency due to new requirements for all 1915C HCBA waivers. With the loss of those waivers, Title V CSHCN funded a respite program for those individuals who were served during the last year of the respite waivers. Approximately 200 families have received financial assistance to fund respite services for qualifying children & youth.//2007//

/2008/ the Title V CSHCN Respite program of 05-06 was completed with respite funding provided to 310 individuals between November 1, 2005 and October 31, 2006. Parental & employee input was obtained about the process for providing respite services during the next application period. The parents consulted felt that family needs vary & they should have the ability to choose how to spend the funds to help their CSHCN, with one of those options being respite. The program for the next year of service (11/1/06 -- 10/31/07) was changed & called the Title V Family Support/Respite Program. The program was funded for a max of 300 slots. Another recommendation from the parents was that the applications should be provided to all eligible people. That meant that over 19,000 applications were mailed out (to all SSI & TEFRA recipients in the state) for only 300 slots. Over 3,750 applications were received. Applications were reviewed on a 1st come 1st served basis with ratings done by a committee of 3 (includes a parent) with averaged scores & rated against a previously set eligibility point (taken from the previous Respite Waiver). The final slot was awarded in June 2007. Title V also paid for about 30 children/youth to attend summer med camps.//2008//

/2009/ The Title V Family Support/Respite Program for 11/1/06 -- 10/31/07 served 300 families of more than 3,750 applicants for the $1,000 award. The agency cost in man-hours to process this number of applications was prohibitive considering the small number of awards made. A change was made in the process, effective 11/1/07. Each Regional Manager was given a fixed amount of funding to utilize for the families of CSHCN within their catchment area. Each of the care coordination staff would use the funding as a resource as they work with families of CSHCN. Applications are completed by the family. The care coordinator is required to make a home visit to meet with the family to discuss the application. The care coordinator rates the application based on a level of need established by prior year programs. The application is then routed to the Regional Manager for review, determination of eligibility and amount of award. To date, 233 applications have been received with 158 awards made. This year, the paperwork processing required for the issuing of payment was brought under CSHCN staff oversight which decreased the amount of processing time for payment. A total of 31 individuals had summer camp covered by the CSHCN program in addition to the individuals discussed earlier.//2009//

/2010/ The Title V Family Support/Respite Program continues to provide financial assistance to qualifying children and youth and their families. Assistance was provided for 255 qualifying children and youth at a cost of $163,947.41 during the time period 11/1/07 -- 10/31/08. In addition to this program, our staff has oversight of the DDS Special Needs program for children and youth. During the same time period, 29 individuals were served at a cost of $31,417.01. //2010//

Title V staff have provided services through the Medical Home Grant which ended March 31, 2005. A no added cost extension was granted. The extension will provide for the continuation of Project DOCC (Delivery of Chronic Care). This project has been coordinated by Rodney Farley of Title V CSHCN & has trained families that serve on the Title V CSHCN Parent Advisory Council to give an overview of the daily tasks that are involved in the lives of CSHCN. They invite Resident Physicians from the University of Arkansas Medical Sciences into their home for a glimpse into their lives & the changes that occurred with the CSHCN. The purpose of Project DOCC is to give physicians a better understanding of what CSHCN & their families go through on a daily basis & how their needs impact the entire family.

/2008/ CSHCN staff have been actively involved in the Arkansas Early Childhood Education Comprehensive Systems (AECCS, also call CISS) grant. With the leadership in DHS of the

Division of Child Care and Early Childhood Education (DCCECE), that collaborative project has advanced to the development and beginning implementation of a "five tiered" Quality Rating Scale for ECE providers. DCCECE is making funds available to incentivize ECEs to advance to higher quality levels.//2008//

/2009/ This year the Arkansas Early Childhood Education Comprehensive Systems grant has seen activity on multiple levels. Pilot studies were completed in both an urban and rural practice with good results noted in both practices. Currently development of a statewide spread strategy is a primary activity. The EPSDT incentives will be effective September 2008. Medicaid has also set in motion a method for reimbursement to physicians for developmental- and autism-specific screening, effect July 1, 2008. //2009//

/2010/ Title V CSHCN staff remains involved in projects within the Department of Human Services to improve the rates of early developmental screening and autism screening. Although committed to providing incentives (billing for Developmental screening tools in addition to separate billing for EPSDT screens) to providers to encourage early screening, Arkansas Medicaid put plans to begin the incentives on hold due to the current economic downturn. //2010//

Through Title V CSHCN contact with families, a database of over 16,000 children & youth is maintained with whom we provide information via an annual newsletter. The newsletter is sent on a quarterly basis to families who have requested Title V CSHCN care management assistance, those who receive services paid for by Title V CSHCN funding & those whose ACS Home & Community Based Waiver case is coordinated by Title V CSHCN staff. The Child & Adolescent Service System Program (CASSP): A statewide council made up of legislatively appointed membership from Human Services, Health, and Education oversees CASSP. Membership also includes consumers, family members, mental health providers & advocacy groups. Fifteen Regional CASSP teams serve the children & youth around the state. Title V CSHCN staff are members of the regional teams & work as part of the team to assure that appropriate services are received.

/2008/ The Title V CSHCN Program Administrator is now a member of the state level CASSP Coordinating Council. Title V CSHCN staff have been very active in working with local CASSP teams over the past year making referrals from one system to the other when working with dually diagnosed children & youth. The CASSP system should be incorporated into the System of Care Initiative that is currently on-going in Arkansas to address the mental and behavioral health needs and care system. The Division Director of DDS, Dr. Charlie Green, has been involved in this initiative from its' inception. System of Care planning has culminated in enabling legislation in the 2007 session of the Arkansas General Assembly. That new law provides the policy basis for developing a statewide system of care for mental health for kids. The State's First Lady is now concluding "Listening Sessions" in all parts of the state to initiate the implementation of this law.//2008//

/2009/ The CASSP program continues to function in its traditional way. The Behavioral Health System of Care program is moving forward in the development of plans to make the systems changes needed to address the concerns brought forward in 2007.//2009//

Together We Can (TWC): DDS is the division responsible for the coordination of TWC. Title V CSHCN staff are members of the local team. TWC is a multi-agency, multi-departmental program that is available in 26 counties. It provides services to children who have multiple needs but unsuccessful services provided in the past. TWC services address intense emotional, interpersonal, or behavioral challenges, a lack of success in traditional services, the need for services from multiple agencies, and the desire to remain in the community.

/2009/ Plans to combine the Together We Can program with the CASSP program began in April 2008 to be effective July 1, 2008. By combining the programs there would be a presence in every

county in the State of Arkansas with funding available to provide for needs that are not covered by other entities. //2009//

Title V CSHCN staff provide leadership of Local Interagency Collaboration Councils (ICC). These teams are regional support for the State ICC that is the state's group monitoring the Early Intervention program. Membership in the local & state team includes DDS staff, Department of Education Early Childhood staff, providers & consumers.

/2007/ Local ICC teams have been targeted by state CSHCN staff to improve participation. This has led to an increase in membership & activities statewide.//2007//

Title V CSHCN staff are members of Hometown Health Initiative (HHI) teams around Arkansas. The CSHCN staff is responsible for assuring that the needs of CSHCN are brought before the local teams. Child Case Review Committee (CCRC) is an interagency team within DHS that brings staff from the Divisions of Children & Family Services (AR foster care agency), the Youth Services, Developmental Disabilities Services, Behavioral Health Services, Medical Services (Medicaid) & the DHS Director's Office to discuss problematic cases that cross divisional lines. The Title V CSHCN Assistant Director is a member of this committee. The Title V CSHCN Program Administrator is a member of the Department of Health Oral Health Advisory Committee and Genetics Services Advisory Committee, and these are explained in greater detail elsewhere in this application. The needs of CSHCN & their families are brought to the attention of these groups. The Title V CSHCN Unit Manager serves on the Medical Home committee for the Arkansas Early Childhood Comprehensive Systems (AECCS) grant with DHS Division of Child Care & Early Childhood Education. By agreement with Arkansas Social Security Disabilities Determination Services office, information is forwarded to the Title V CSHCN program when they receive an application for SSI on any child or youth less than 16 years of age. Referrals are made for other services/programs for which the individual may also be eligible (e.g. Part C EI, DDS, Title V CSHCN & Mental Health). Approximately 2,000 such referrals were made during FFY 04.

4. The WIC population

The mission of the Women, Infant and Children program (WIC) is to improve the health of infants, children and childbearing women by directly supplementing their diets with foods rich in nutrients they need, providing nutrition education and counseling and referrals to other services.

The mission of WIC Farmers' Market Nutrition Program is to encourage the consumption of fresh fruits and vegetables by WIC participants and encourage the development of farmers' markets.

Target Population
WIC: Pregnant, breastfeeding and postpartum women, infants and children under age five are eligible if they live in Arkansas, are income eligible and have a condition or living situation which places them nutritionally at risk. Income eligibility is based on 185% of the federal poverty guidelines.

FMNP: Women and children who are WIC participants in the counties with authorized farmers' markets are eligible.

Description of Services
Risk Assessment: A screening to determine nutritional status is performed on each applicant by a nurse, nutritionist, home economist, or physician.

Food: WIC participants receive nutritious, prescribed foods and purchase these foods as listed on WIC checks (bank drafts) at local grocery stores. FMNP participants receive coupons, not to exceed $20, to purchase locally grown fruits and vegetables at farmers' markets.

Nutrition Education:
·Nutrition Counseling - Participants with potentially serious nutrition-related health problems are scheduled for individual counseling by nutritionists.

·Nutrition Education -- All participants or parents of participants are offered nutrition education including the selection and use of fresh fruits and vegetables in counties where FMNP is available.

·Breastfeeding Promotion and Support - All pregnant women are informed of the benefits of breastfeeding their infants. Breastfeeding women receive support services from trained health providers and may receive breast pumps.

Referrals to Other Services: WIC participants are referred to other services as needed by local clinic staff. Strong emphasis is given to childhood immunizations and prenatal care.

5. Women and men of reproductive ages (Family Planning)

The purpose of the Reproductive Health Program is to provide reproductive health services to women and men, enabling them to choose the number and spacing of children and prevent unplanned pregnancies. Reproductive Health services include health history assessment, laboratory tests, physical assessment, contraceptive methods, health education, treatment and referral.

Target Population:Men and women of childbearing age in the State of Arkansas, primarily the low-income clients who are uninsured and under insured.

//2008// Women at high risk of unintended pregnancy will continue to be high priority populations for the Family Planning Program, to include: teens, minorities, low income women, women without insurance, and unmarried women.

Services offered to all clients include Health History Assessment, Laboratory Tests, Physical Assessment, Contraceptive Methods, Health Education, Treatment and Referrals. Clients are also strongly counseled on immunization needs. The Reproductive Health Program implemented health records specifically for male clients seeking reproductive services. These services are available to all Arkansas residents at ninety-two (92) Local Health Units (LHU) and one (1) contracted agency.//2008//

Description of Services
The Reproductive Health Program provides, through ADH and delegate agencies, clinic based family planning services to women in need of publicly supported services. Eighty percent of these women will be at or below 200% of poverty according to declared income and family size. In addition, the program provides outreach and education to hard to reach populations regarding family planning. This includes education on abstinence and male responsibility. The program also detects precancerous and cancerous changes of the uterine cervix through Cervical Cytology Screening.

The objective of unwed birth prevention efforts is to prevent pregnancies to unmarried teens throughout Arkansas. A variety of methods are utilized to include health education, outreach, and increased access to family planning services. During 2004 nine (9) County Coalitions targeted eleven (11) counties and reached eight thousand one hundred ninety-six (8,196) youth through facilitation of "Programs That Work" curricula. An additional eight hundred twenty-seven (827) youth received family planning services while two hundred thirty-seven (237) participated in Teen Outreach Programs, fifty-nine (59) participated in male responsibility programs, and five hundred seventy-two (572) utilized Baby Think It Over simulators.

6. Target population: Medicaid Recipients in AR Kids A and B

/2010/ The Health Connections Section (HCS) in Family Health, through a hotline, communicates with new enrollees in AR Kids A and B to link the children to a PCP, and to case manage them for initial dental appointments. Up-to-date lists of physicians, dentists, and enrollees are maintained by Medicaid and HCS is provided with updated computer databases to track and inform newly enrolled families. HCS also provides through its health education staff community based outreach education to promote Medicaid use by adolescents in the school setting. //2010

C. Organizational Structure

A. Introduction

/2008/ During the 2007 session of the Arkansas General Assembly, the members passed a law allowing the governor to separate the health agency from the human services agency, two agencies which were merged by the 2005 General Assembly. As of July 1, 2007, the Division of Health separated from DHHS, to become again the Arkansas Department of Health (ADH), a cabinet-level agency. This necessitates ADH re-building of agency-level infrastructure such as financial management, human resources, information technology, and other administrative support services. The two new agencies are cooperating on this endeavor to make as smooth a transition as possible. While attention is being given to these administrative needs, programmatic needs are also being taken into account. Care is being taken that the inter-divisional processes set up for collaborative efforts which benefited from the unified organization will continue to flourish even though the departments are separate. ADH staff participate actively on the Early Childhood Commission (DCCECE), in the AECCS (CISS) process, in the System of Care for Mental Health process, in the ICC for Part C of IDEA, ANGELS (perinatal high risk referrals) and a host of other linking opportunities.//2008//

//2010// The ADH continues steady development of its administrative units subsequent to demerging. Administrative processes have been streamlined, and program support is greatly strengthened.

B. Organizational structure by the MCH subpopulations

1. Pregnant women and infants organizational structure

/2008/ The Perinatal Program is a part of the Women's Health Section of the Arkansas Department of Health. Women's Health is a section in the Family Health Branch of the Center for Health Advancement. The Perinatal Program provides support and guidance to the public health units through research, development, revisions and directing and assisting with the implementation of program policies and procedures. Women's Health Perinatal staff includes a chief physician consultant, who is board certified as a Fellow of the American College of Obstetrics/Gynecology and a BSN Registered Nurse, with extensive experience in maternal child care and public health. Advanced Practice Nurses and Registered Nurse Practitioners, along with the public health nursing staff provide clinical services at the local health units managed within the Women's Health Section.//2008//

/2008/ The Perinatal Advisory Board was allowed to "sunset", effective July 1, 2007 by Act 153, due to a review of Government Efficiency and Accountability Subcommittee's recommendations. The Perinatal Advisory Board held its final meeting November 20, 2006. Prior to that Board attendance, for several meetings was insufficient to conduct business, and its recommendations seldom received attention from the governor and legislature. This Board was supported and coordinated by the Perinatal Program.//2008//

/2009/ The organizational structure of the Women's Health Branch remains the

same.//2009//

2. Organizational structure for children

/2007/ The Child and Adolescent Health (CAH) Section of the Family Health Branch Houses children's' health programs. Until recently, CAH was guided by a physician who is board certified in Preventive Medicine and clinically trained in pediatrics. That physician has resigned. The Division of Health plans to replace that position. Ms. JoAnn Bolick, a pediatric Advanced Practice Nurse with a Masters in Business Administration, who has served children in this agency for over 20 years, was appointed Section Chief for CAH. She will provide critical new leadership in programs for children. The Family Health Branch leaders intend the Section to bring new emphasis to developing interagency collaboration and broad partnerships in improving services for children. Heavy use of the Block Grant dollars to sustain the immunization program continues, but a new emphasis is being brought to Coordinated School Health, to Early Childhood Comprehensive Health Systems, and to outreach and case management. These emphases should all benefit from the merger of the two former departments. Three major developing partnerships for children include Coordinated School Health, Early Childhood Comprehensive Systems, and Child Mental Health Initiatives. //2007//

/2008/ The Child and Adolescent Health Section of the Family Health Branch will be enhanced beginning July, 2008. The Board of Health and the state legislature have provided rules changes, budget authorization, and positions to expand the New Born Screening program from its current 9 conditions to encompass the 29 conditions currently recommended nationally for all states to include in Newborn screening panels. A scientific "white paper" was produced in the summer of 2007, outlining a plan for the expansion and stating the need to increase the fee to $89.25 per infant tested. In addition to PKU testing, tandem mass spectrometry will be added, checking for other aminoacidurias, fatty acid oxydation disorders, and organic acid disorders, as recommended. The fee will also include the addition of screening for Congenital Adrenal Hyperplasia, Cystic Fibrosis, and Biotinidase. July 1, 2007 will see the beginning of recruitment of needed additional follow-up staff, including a .5 FTE pediatrician, and full-time staff including a Program Nurse Manager, two additional nurses, an LPN, an administrator, and a database manager; and additional laboratory staff to accommodate the added lab testing procedures. The current plan is to cover the other .5 FTE of the pediatrician to guide other child health programs, but especially to pay attention to interagency collaborative efforts that enhance the system of care for children. //2008//

/2009/Expansion of the Newborn Screening Program to detect the 29 nationally recommended conditions began as of July 1, 2008. The State Laboratory is now screening for all 29 conditions, and billing for the new $89.25 fee. In June The Family Health Branch hired J. Robert West, MD, MPH, a board certified pediatrician who is very knowledgeable about Newborn Screening and has previously served in the agency. The CAH Section has hired two new public health nurses as Newborn Screening Consultants, and is finalizing hiring of the administrative nurse to guide the staff effort and another public health nurse to also assist with follow-up. ADH has signed a contract with the UAMS Department of Pediatrics for the medical guidance and technical assistance needed to manage the screening and diagnostic process. A contract is planned with Arkansas Children's Hospital covering arrangements for second tier testing. Detailed protocols have been written, and will be adjusted as needed.//2009//

/2009/ Dr. West was hired full time into the position of the Deputy Chief of the Family Health Branch. As the activities of the Newborn Screening Program become more routine, Dr. West will assume medical leadership of all CAH Programs.//2009//

/2010/ The NBS expansion has unfolded without major problems. With support from HRSA

and CDC, the Newborn Hearing Screening program continues to increase its success with follow-up for children who fail the initial screen. Abstinence Education grants are scheduled to end June 30th. //2010//

3. Organizational structure for Children with Special Health Care Needs

Historically, in Arkansas the Title V CSHCN program has been housed in DHS. The transfer of the Title V CSHCN program (formerly known as Children's Medical Service or CMS) from the Division of Medical Services (Arkansas' Medicaid entity) to the Division of Developmental Disabilities Services led to reorganization within DDS to structure the agency into Children's Services and Adult Services with other sections providing fiscal management and quality assurance resources. Prior to the intradepartmental move, the Title V CSHCN program and DDS served many mutual consumers. DDS had and still has a scope of eligibility that includes Cerebral Palsy, Seizures, Autism, Mental Retardation and any "other condition" that causes an individual to function as though they are Mentally Retarded. The Title V CSHCN program covered Cerebral Palsy, Seizures and some of the "other conditions", but did not cover Autism and Mental Retardation. Title V CSHCN, following national definitions, covered and still covers a wide range of medical conditions such as Cancer, type I Diabetes, severe Asthma, Spina Bifida, orthopedic anomalies, injuries and many, many other conditions. These conditions are outside the range of typical DDS consumers so that the DDS scope of service is somewhat narrower than CSHCN. As the Title V CSHCN staff transitioned into DDS they have been assigned duties and caseloads for other DDS programs. These programs provide services to CSHCN and are an additional resource for families. Although there are more employees, the combined caseloads remain too large for staff to effectively manage. This has led to concerns among veteran Title V CSHCN staff, the Parent Advisory Council and others that traditional Title V CSHCN consumers are being neglected. Using the long-held definition of CSHCN, all of the individuals served through the DDS programs are children with special needs and are deserving of Title V CSHCN staff efforts to assist in meeting their needs and personal goals. The over-riding issue is whether it is realistic to believe that a relatively small staff can adequately handle the caseloads that result from these various programs.

//2008// As of this writing (June 2007), possible reassignment of CMS Care Coordination staff to focus on medically complicated children with special health care needs is under consideration.//2008//

//2009// The reassignment of Part C Early Intervention job tasks took place as planned allowing all except four of the care coordination staff to concentrate on work with medically complicated and developmentally delayed children, youth and their families. At this time, two of the care coordinators continue to work with the Part C program until that program is able to hire staff.//2009//

/2010/ All Title V CSHCN professional staff have been relieved of care coordination duties related to the Part C Early Intervention program and have returned to work full time in our program.//2010//

4. Organizational structure for WIC services

The WIC Program, along side the Women's Health and Child and Adolescent Health Work Units, is housed in the WIC Work Unit of the Family Health Services Unit. WIC clinic services are provided in all 94 local health unit sites, as are food instrument services. Farmers' markets are developed in selected sites in the state. The WIC Work Unit is supported by the Regional Leadership Teams who assure management through the District Managers and Administrative Leaders of Local Health nits.

/2007/ The WIC Program is now placed as a Branch within the Center for Health Advancement, and will house the leadership of nutrition services as well. Mr. Marcell Jones serves as its

Associate Chief, and a Chief is being recruited.//2007//

/2008/ WIC staff has been working diligently on the development of Value Enhanced Nutrition Assessment (VENA). A new process of doing nutrition assessment in WIC. They will be adopting the health outcome based nutrition assessment. This for all patient types. //2008//

/2010/ VENA has now been adopted in all WIC locations, and the new electronic record system (SPIRIT) has been implemented. Mr. Marcell Jones has retired, and Ms. Susan Handford, a Nutritionist and an experienced WIC administrator has assumed his position in the interim while recruitment is carried out. VENA is a health-outcome based process that focuses on the prevention of health problems and the applicant's expressed needs and concerns, including obesity -- not on what the participant is doing wrong. With the VENA process, our WIC staff is able to personalize nutrition services through individualized nutrition education, food package tailoring and referrals to other health and social services.//2010//

/2010/ Additionally, our new WIC food packages will finally contain food choices that promote key nutrition messages including those for obesity prevention. These key nutrition messages are: 1) Eat more fruits and vegetables, 2) Lower saturated fat and cholesterol intake; 3) Increase whole grains and fiber; 4) Drink less juice and sweetened beverages; and 5) Babies are meant to be breastfed. With the implementation on October 1 of this year new food packages will follow the goals of the Dietary Guidelines for Americans (promote health and reduce risk for chronic diseases like obesity and others). The new food packages are healthier for all participants, and may help prevent obesity by: 1) including lower calorie foods, such as low fat or fat-free milk, fruits, and vegetables, 2) reducing higher calorie foods like cheese, eggs, and juice; 3) providing fiber in the form of whole grains, beans, fruits, and vegetables; 4) promoting healthy eating habits for infants, such as delaying solids until around 6 months; and 5) encouraging exclusive breastfeeding.//2010//

/2009/ Current Agency structure, moving from Section Chief related to mothers and children upward, the leading staff includes: In Health Connections - Mary Gaither, an experienced public health nurse administrator; in Women's Health - Sharon Ashcraft, an experienced public health maternity nurse and RNP; in Child and Adolescent Health - JoAnn Bolick, a pediatric nurse practitioner with long experience in program administration. In Family Health - Mr. Bradley Planey is Associate Branch Chief and has experience administering mental health, family planning, maternity and abstinence education programs; Robert West, MD MPH is Deputy Branch Chief with many years experience in managing child health programs especially Newborn Screening; and Dick Nugent MD MPH Branch Chief, with lengthy experience leading MCH programs. At this time, all Sections staffs are complete with the exception of the managing nurse for the Newborn Screening (NBS) expansion (Recruitment in process) and two help line specialists in Healthy Connections. After July 1, six new positions are funded from Medicaid to enhance outreach to Medicaid eligible children.//2009//

/2010/ The NBS managing nurse position has been filled with Ms. Annette Arnold, an experienced public health nurse. //2010//
An attachment is included in this section.

D. Other MCH Capacity

1. Introduction

/2008/ In the interests of brevity, clarity and space, this section has been modified from earlier applications by removal of out-dated organizational descriptions. Other capacities in the Arkansas Department of Health (ADH) include staff in Centers other than the Center for Health Advancement (where MCH is administered) that work on or collaborate with MCH programs. The

Center for Health Protection is headed by Mr. Donnie Smith, a professional health educator who has had long experience with management of many health programs. In the past, Mr. Smith served as the Administrative Director of the MCH programs. He is assisted by Dr. James Phillips as Associate Director for Science, and Mr. Ron Stark as Associate Director for Management and Operations. Mr. Stark has long experience with management of MCH programs in the Department, and also with management of Medicaid programs in DHS that relate to women and children. //2008//

/2008/ The State Center for Health Statistics, now the Health Statistics Branch (HSB) in the Center for Health Practice, manages many data bases that are of critical importance to MCH, especially birth and death certificates, hospital discharge, PRAMS, BRFSS and local YRBS data bases. HSB also manages professional registries for licensed health professionals. HSB maintains a staff of highly skilled statisticians who are trained in SAS software use. They assist epidemiologists and program directors with data needs for agency performance, strategic planning, and program registries such as cancer and immunization. The HSB manages the State Systems Development Grant (SSDI) which supports a rich network of data linkages being developed by the Health Department. For example, with SSDI and other resources have enabled HSB to link birth certificates to infant death certificates, hospital discharge data, PRAMS survey data, Medicaid enrollment and billing information, and a variety of other data sets. The SSDI grant, along with other resources provides as much state data capacity as programs can use. The 2006 block grant application, requiring the 5 year needs assessment, called for a number of new measures. The HSB was able to respond to these requests in a very timely manner with up-to-date information.//2008//

/2009/ The Center for Health Practice (CHP), headed by Dr. Glen Baker, houses the Epidemiology Branch composed of Senior Epidemiologists serving all programs of the ADH. Ms. Terri Wooten is located in this Branch. Ms. Wooten serves as the MCH Epidemiologist and provides major assistance in developing the MCH Block Grant applications. //2009//

/2010/ The ADH/CHP/Health Statistics Branch has established a contract with ManTech Solutions and Technology Corporation for implementation of the Electronic Vital Records System. The Infant Hearing Program in the Child & Adolescent Health Section/Family Health Branch is collaborating with this initiative that includes an Infant Hearing Screening Module as part of the implementation plan. //2010//

/2010/ ADH, its Center for Health Advancement and Family Health are all deeply enmeshed in "networking the networks" and this has resulted in significant expansion in partnerships addressing pregnancy and infant health, systems of child health services, services for children with special health care needs, and services to improve women's health. This effort has enjoyed the encouragement of the Governor's Office. Never before in Arkansas has there been as much shared examination and planning by the major health organizations and institutes. //2010//

2. Other MCH capacities can also be described by the MCH subpopulation group.

a. Infants and Pregnant Women

The OBGYN and Pediatric Departments of UAMS provide medical leadership for infants and pregnant women that extends to all parts of the state. The Maternal and Fetal Medicine (MFM) faculty, and the Neonatology faculty, provide medical training for obstetricians and pediatricians who graduate from residency training to practice in larger communities. The two subspecialty faculties also conduct an annual Perinatal Conference in Little Rock, attended by obstetricians, pediatricians, and family physicians, as well as hospital and office nurses in relevant practices. With contractual support from the Division of Health, the MFM Division provides outpatient clinic services for pregnant adolescents, and a special clinic for pregnant women with gestational diabetes. These clinic services and the prenatal clinics in local health units throughout the state

are served by a coordinated system for consultation and referral operated by the high risk maternity services of UAMS. The Directors of the Maternal Fetal Medicine and Neonatology Divisions, with financial support from the Medicaid Program, have begun an effort called Antenatal and Neonatal Guidelines for Education and Learning Systems (ANGELS). ANGELS has many purposes and activities. Among them is a statewide telemedicine network for obstetricians and neonatologists. This network holds a teleconference every Thursday morning at 7:00 AM to present cases, discuss new evidence-based guidelines for obstetrical and newborn care, and to include community physicians in the process of writing the ANGELS guidelines. The guidelines are published both on the UAMS web page and by distribution of copies on compact disks to physicians in appropriate specialties. MCH staff from the ADH actively participate in these efforts.

The Community Health Centers Program of the Division, aided by the Primary Care Association of Arkansas, develops and maintains the network of 51 Community Health Centers throughout the state. Many of these Centers provide obstetrical care, and are located in medically under-served counties. The Area Health Education Centers train family physicians and also provide training in obstetrics, including the ability to perform cesarean sections for those physicians interested in this practice. While the AHEC's primary objective is training, a significant capacity to provide prenatal care exists in the AHECS in certain communities. The Primary Health Care Association supports the Statewide Health Access and Resources Program (SHARP), a collaborative planning and policy development group intended to bring together HRSA funded programs in the state. MCH staff participate actively in these efforts.

/2008/ The University of Arkansas for Medical Sciences Obstetrics /Gynecology and Pediatric Departments provide medical leadership for infants and pregnant women that extends to all parts of the state and beyond. The Arkansas Department of Health and Human Services, Division of Health provided for 84 hospitals to receive teleconferencing equipment through a Health Resources and Service Administration National Bioterrorism Hospital Preparedness Program grant. UAMS ANGELS provides a weekly telemedicine conferences to enable physicians to confer with maternal-fetal medicine specialists in real-time about individual cases. In addition, ultrasounds can be read in real-time, and ANGELS offers assistance in training local technicians. Clinical telemedicine consultations are available that allow patients, local physicians, and UAMS physicians to talk together and see each other, bringing subspecialty support directly to hometowns. Three teleconferences are offered at this time: High Risk Obstetrics, ANGELS Neonatal and Obstetrical Nursing Exchange (ONE). The High-Risk Obstetrics Teleconferences are offered every Thursday, the ANGELS Neonatal Teleconference is held on the third Thursday of every month, Obstetrical Nursing Exchange (ONE) is held on the first Friday of every month. Plans are in the making for an additional teleconference, FAIM, or Fetal Anomaly Interdisciplinary Management, that will be held monthly via teleconference at several locations around Arkansas, including UAMS and Arkansas Children's Hospital. ANGELS also provides a call center to provide 24-hour support for physicians to consult with maternal-fetal medicine specialists when requested regarding patient management issues.//2008//

/2009/ Dr. Richard Nugent, Family Health Branch Chief, also serves on the Evaluation Team for the ANGELS Program, which is also greatly assisted by Dr. John Senner of the ADH/CHP/Health Statistics Branch and his staff person Shalini Manjanatha who does linking. That evaluation is funded by Medicaid (CMS), and is contracted to a nationally recognized Epidemiologist, Dr. Janet Bronstein of the University of Alabama at Birmingham. The evaluation team meets weekly by telephone.//2009//

/2010/ The ANGELS Evaluation Team has gathered and analyzed linked birth/infant death/hospital discharge records to Medicaid Claims records for a 2-year period before ANGELS began and for a 2-1/2 year period after. Papers are being prepared for publication in a number of interesting areas of the evaluation.//2010//

/2008/ The Women's Health Section, Perinatal Program, provides the semi-annual Maternity

Training Program for Public Health Nurses. These trainings were held in February and August 2007. This is a continuing education opportunity to provide the skills and information needed by Public Health Nurses to obtain histories, identify problems and make proper referral for the pregnant women in our maternity clinics. Public Health Nurses and Maternal Infant Nurses from throughout the state attend this four day training in Little Rock. Nurses earn Continuing Education Contact Hours approved by the Arkansas Nurses Association. The training is primarily focused on nurses new to the provision of maternity services, with an average of eighteen to twenty two participants. The presenters are experts in the field of maternity care from the Division of Health, UAMS, and other health care providers. The nurses attend the ANGELS ONE teleconference as one of the training sessions.
//2008//

b. Children's Services

/2008/ The Department of Health contracts with the Department of Pediatrics at UAMS for certain services to children. Primarily this contract is intended to provide coordination of hospital discharge plans for newborns leaving neonatal intensive care. The Pediatric Department's Neonatology services work very closely with the maternal fetal medicine services to coordinate perinatal services at UAMS. The two services together mount an annual perinatal conference, training over 300 health professionals, mostly doctors and nurses, regarding new developments in perinatal medicine. These conferences also address development of programs for infants and pregnant women.//2008//

/2009/ This year a significant new contract was established with the UAMS Department of Pediatrics to provide medical specialty guidance and technical assistance for the expansion of the Newborn Screening Program. That contract also serves as a "business agreement" under HIPAA regulations covering the sharing of patient data. //2009//

/2008/ The ADH and DHS in their former arrangements had an ongoing liaison committee that met on an approximately monthly basis. In the new Department of Health, this function will happen more routinely during regular meetings of the Division Directors.//2008//

/2009/ Relationships between the now-separate Department of Health and Department of Human Services (DHS) are maintained by meetings, as needed, between the ADH and DHS executive staff. Many new grants and strategic planning opportunities have occasioned meetings at Center and Branch levels.//2009//

/2008/ The Arkansas Children's Hospital (ACH) is among the top children's hospitals in the country. It provides subspecialty care, conducts research, and assists with public awareness and promotional aspects of developing services for children. ACH has developed outreach clinics for many pediatric specialties in more rural areas of the state. In addition to the Pediatric Department of UAMS, ACH is the main institutional provider of highly specialized pediatric services in the state. ACH operates a helicopter transport system for emergency evacuation of sick newborns. //2008//

/2009/ With the expansion of the Newborn Screening Program to the recommended 29 conditions, detailed negotiations and collaboration have occurred with the Arkansas Children's Hospital, especially its Laboratory concerning second tier screening tests, and referrals to subspecialty clinics.//2009//

/2010/ A Memorandum of Agreement (MOA) with the Arkansas Children's Hospital has been established formalizing the relationship for second tier testing for Cystic Fibrosis and Congenital Adrenal Hyperplasia for the expanded Newborn Screening Program. That MOA also establishes a "business agreement" under HIPAA regulations for sharing of protected health information. //2010//

c. Services for Children with Special Health Care Needs

The Director of the Division of Developmental Disabilities Services in DHS is James C. Green, PhD. His background is in Special Education. Current program leadership includes Regina Davenport, Assistant Director for DDS Children's Services. Ms. Davenport has a B.S. in Psychology from Arkansas State University with post-graduate work in counseling and Special Education. Her professional background is in developmental disabilities. Nancy Holder, RN, Program Administrator has an Associates Degree in Nursing from Memphis State University. Her professional background is in CSHCN, typically the medically involved child and youth. Eldon Schulz, M.D. with the University of Arkansas Medical Sciences Department of Pediatrics is currently serving under contract as Medical Director for the Title V CSHCN program. His professional background is in Developmental Pediatrics.

Since the transfer of the Title V CSHCN program from DMS to DDS, the make-up of the casework staff has expanded. A statewide Regional Management team of six includes four Registered Nurses, one Social Worker and one Service Specialist. Each of these Regional Managers supervises employees that include Registered Nurses, Social Workers and Service Specialists. Title V CSHCN staff are housed in 26 of the 75 counties in the state in DHS-operated offices. The RNs on staff have a minimum of two years experience when hired, with the current average years of experience with CSHCN being 19 years. The Social Workers on staff are licensed Social Workers or are individuals that have education and experience with CSHCN and are in positions which allow them to function in a Social Work capacity. The Service Specialists must have either a BS or BA degree with 2 years experience working with the developmentally disabled. The Title V CSHCN program currently has on staff: 22 Clerical Staff; 15 Registered Nurses, 7 Social Workers, 9 Service Specialists and 1 Psychological Examiner in community-based offices. There are 8 Management staff with 4 housed in community-based offices and 4 in central office. There are 23 Central Office support staff (administrative and clerical). Of the 85 total employees, 8 have children with special health needs. One is the Parent Consultant, 3 are Registered Nurses, 2 are Social Workers and 2 are Service Specialists.

/2007/ Over the past year, our staff has decreased due to retirements and resignations. Replacement of those employees was postponed until after July 2006. We anticipate rehiring staff in the first quarter of the state fiscal year. There are currently 71 employees on staff either full or part time. Of those employees, 9 have children with special health needs. This includes the Parent Consultant, 1 Registered Nurse, 2 Social Workers, 3 Service Specialists and 2 clerical staff.
//2007//

Rodney Farley serves as Parent Consultant for the Title V CSHCN program. In this position he serves on a number of committees as a parent of a child with special needs and as an advocate. The committees he serves on include Partners for Inclusive Communities (Arkansas' University Affiliated Program) Consumer Committee; Arkansas Parent Information Exchange; Parent Training Information Governing Board; Advocates Needed Today (ANTS); Can-Do Committee; Parent Educator Advisory Committee; Arkansas Children's Hospital Rehab Advisory Committee and he serves as Family Voices Region VI Coordinator. Rodney works with the Title V CSHCN Parent Advisory Committee. As the parent of a young adult with special health care needs, he is able to give advice and assistance to parents with children of all ages. The Parent Advisory Committee (PAC) for the Title V CSHCN program was formed 15 years ago and involves volunteers from around the state that are parents of CSHCN. The PAC meets quarterly. The PAC members are responsible for setting up local meetings to take information to more parents and work to set up support groups around the state.

/2009/ The Title V CSHCN program staff is experiencing minor personnel changes related to retirement of long-time staff. Rehiring is in process at this time.//2009//

/2010/ The level of staffing of the Title V CSHCN program has remained relatively stable,

but much smaller than in times past.//2010//

d. ***/2010/ With regard to staffing for basic preventive services in LHUs such as WIC, Immunizations, STIs, also applying to Family Planning and Maternity, ADH is now facing budget constraints requiring serious reductions by attrition. These changes will probably be reflected in continuing slight declines in productivity in these, our most gap-filling efforts. //2010//***

E. State Agency Coordination

E. State Agency Coordination

Introduction

/2008/ In its 2007 session, the Arkansas General Assembly authorized the Governor to separate the Department of Health and Human Services (DHHS) to form the Arkansas Department of Health (ADH) and the Department of Human Services (DHS). The Governor ordered the separation. Below, descriptions of the DHHS have been removed in the interests of clarity and brevity. Those descriptions may be referenced in last year's application. Mr. John Selig continues to direct DHS and Dr. Halverson continues to lead the ADH and its relationship to the Legislature. Also, the Board of Health remains largely intact and will relate just as closely to the ADH. Dr. Joe Thompson has been named State Surgeon General, a role in which he will serve as a policy consultant to the Governor and Senior State Agency Officials, be a non-voting member of the Board of Health and perform other advisory functions. Both Dr. Halverson and Dr. Thompson will have cabinet-level positions. Because all leaders remain committed to continued collaborative relationships, we believe that any impact on programs will be minimal. ADH will relate directly to the Department of Finance and Administration for budget and personnel decisions. A new table of organization is appended. //2008//

State agency coordination exists on many levels including state government human service agencies, state-level commissions and partnerships (both existing and developmental), state-local health agency relationships, and local human-services agency interactions.

State government and human services agencies

/2008/ Despite the separation of the DHHS, three important partnerships continue to develop - The Child Mental Health System of Care Initiative, the Arkansas Early Childhood Comprehensive Systems, and the Coordinated School Health partnerships. Developments in these areas are described in later sections of this application. //2008//

State-level commissions, partnerships and advocacy groups

Among many such groups, a few stand out as being particularly important. Longstanding commissions include the Commission on Child Abuse, Rape and Domestic Violence and the Child and Adolescent Service System Program (CASSP). They bring policy and public prominence to these issues. The Arkansas Advocates for Children and Families has played a major role over the years in public policy for the needs of children in general. The Interagency Coordinating Committee was established for IDEA and continues to help state agencies collaborate around the educational and health needs of at-risk children.

/2009/ Dr. Nugent participates as a member of the CASSP Coordinating Committee, and as a voting member of the Early Childhood Education Commission. He also serves as the Medical Home Committee Chair for the Arkansas Early Child Care Comprehensive Systems (AECCS) planning group, and on the Stakeholders' Committee for the Assuring Better Child Development Technical Assistance grant. Ms. JoAnn Bolick serves on the Core Team for AECCS. Dr. Nugent also represents the ADH on the Child Health Advisory Committee (CHAC) described below, and

participated actively in the interagency planning effort that initiated the System of Care for Children's Mental Health. Ms. Bolick and the Child and Adolescent Health Section staff provide administrative support for the CHAC. //2009//

/2010/ Dr. West has assumed membership for Dr. Nugent on the CHAC and the CASSP Coordinating Committee. Dr. Nugent continues to collaborate with the DHS Division of Child Care and Early Childhood Education (DCCECE) on the Arkansas Early Childhood Partnership (AECP) and its Medical Home Subcommittee. That subcommittee is busily developing a Medical Home Tool Kit. Dr. Nugent continues to serve in the Early Childhood Commission, a governor's advisory group to the DCCECE. Dr. Nugent also continues to serve on the Evaluation Team for the ANGELS perinatal referral program at UAMS, Dept of OBGYN.//2010//

Several developmental state partnerships and institutions are making great strides in collaborative efforts for children. Among them the most prominent as a new effort is the Child Health Advisory Committee (CHAC). ACT 1220 of 2003 created this group to address childhood obesity and develop statewide nutrition and physical activity standards. The Committee meets monthly and makes policy recommendations to the State Board of Education and the State Board of Health. Major tasks mandated by the Act include: 1) Removing elementary school student in-school access to vending machines offering food and beverages; 2) Developing recommendations to ensure that nutrition and physical activity standards are implemented to provide students with the skills, opportunities and encouragement to adopt healthy lifestyles; 3) Requiring schools to include as part of the annual report to parents and the community the amounts and sources of funds received from competitive food and beverage contracts; 4) Requiring schools to include as part of each student's health report to parents an annual body mass index (BMI) percentile; and 5) Requiring schools to annually provide parents an explanation of the possible health effects of body mass index, nutrition and physical activity. Organizational memberships in the CHAC include: Division of Health, Dietetic Association, Academy of Pediatrics, Academy of Family Practice, Association for Health, Physical Education and Dance, Heart, Cancer and Lung Associations, College of Public Health, the Arkansas Center for Health Improvement, Arkansas Advocates for Children and Families, U of A Cooperative Extension Service, Department of Education, School Food Services Association, School Nurses Association, the Association of Education Administrators, and the Parents and Teachers Association. The CHAC made strong recommendations to the Department of Education, and the Department Adopted regulatory requirements with direct impact on the nutritional environment in schools.

/2008/ The CHAC now provides guidance for the Coordinated School Health Program, funded by CDC, as well as the requirements of Act 1220. The 2007 session of the General Assembly made several significant changes in the rules promulgated under Act 1220. BMI measurements are to be made only every other grade, and the total time required for students to be involved in physical activity has been reduced. The BMI measurement change will have only a minimal affect on the ability to assess program impact, because measurements will still be made every year, just not in every grade. The reduction in required physical activity may have a more problematic impact, long term. //2008//

/2008/ The CHAC has developed a sub-committee to address the Arkansas Early Childhood Comprehensive Systems partnership. The sub-committee keeps the CHAC updated on progress toward the implementation of the Quality Rating System (QRS) being developed for Early Childhood Education providers. A five-tiered QRS for all aspects of ECE, and including a comprehensive set for health issues, has been proposed, "vetted" with leaders of ECE providers in the state, and is taking a more settled form. Very detailed work with ECE providers has brought the focus to clear, operational, and realistic expectations for the first three tiers of the guidelines. The Division of Child Care and Early Childhood Education that licenses day care centers, has assumed the leadership of applying these as voluntary guidelines, and has even identified funds to incentivize providers to enhance their services. //2008//

/2009/ Out of the collaborations developed by the Early Childhood Comprehensive Systems (AECCS), The Assuring Better Child Development (ABCD), and System of Care for Children's Mental Health (SOC) planning processes, an interagency committee was formed which wrote and submitted a grant application for Project LAUNCH. The project envisions creating an Early Childhood Partnership Council to coordinate the many streams of public and private interests in children 0-8. The Council will be initiated whether or not the grant is funded. Funding will be used primarily to coordinate services at the community level for young children.//2009//

/2010/ The Arkansas Early Childhood Partnership is now operational and serves as the AECCS initiative's oversight group. The Partnership's committees include Medical Home, Social/Emotional, Early Childhood Education, Family Support, and Parent Support subgroups. The Medical Home Committee is embarked on developing a Medical Home Tool Kit. The Family Support subgroup is working actively with the Medical Home subgroup to link their activities and to enhance planning and policy development for youth and families in both subgroups. This collaborative also links to Leadership in the Division of Behavioral Health guiding the System of Care for Children's Mental Health. The same group of leaders collaborated on a second competitive submission to Project LAUNCH from SAMHSA. //2010//

In 2002 the University of Arkansas for Medical Sciences (UAMS) announced the opening of the College of Public Health (COPH), in partnership with the Arkansas Department of Health. This summer (2005) the COPH will be dedicated and named in honor of the late Fay Boozman. The COPH includes the shared missions of 1) meeting the public health workforce needs for the future and 2) demonstrating how public health approaches can address the health needs of Arkansans via model community programs. Pilot sites for teaching and learning also serve as innovative laboratories for new and creative approaches to old problems. Students learn, with the expert aid of local citizens, schools, hospitals, and faith groups about community-based health improvement. The COPH statewide approach to education includes partnerships with other universities and institutes of learning. For example, students may choose from approved courses at any of several state universities, or via the Internet from an even broader range of course options. During the 2003-2004 academic year, the COPH offered a Post-Baccalaureate Certificate, Master of Public Health (MPH), and DrPH in Public Health Leadership degree programs.

As with other UAMS colleges, the standards of teaching and learning are high and the resources for academic and social life are excellent. The mission of the College of Public Health at UAMS is to improve health and promote well-being of individuals, families, and communities in Arkansas through education, research, and service. The College of Public Health has elected to address its mandate to improve the health of Arkansas by adopting a community-based health education model. The long-term vision is of "optimal health for all Arkansans." By joining forces with pilot communities, the College establishes a model process for statewide health improvement. COPH students, faculty and staff participate in close partnership with local organizations, citizens and public officials. In-service teaching and learning opportunities for COPH students will be concentrated in these pilot communities to the benefit of all involved.

/2008/ In the Fay W. Boozman College of Public Health (COPH), two new PhD programs, one in the Department of Health Policy and Management, and one in the Department of Health Behavior and Health education have accepted students and are conducting classes. Having accomplished these new degree programs, the COPH passed its second review by the national Council for Education in Public Health (CEPH), its accrediting body. That accreditation will continue for five years.//2008//

/2007/ Formerly an academic department at the College of Public Health, the Maternal and Child Health teaching program has been reorganized. The MCH Department is now the Center for MCH Studies at the college, and its course offerings have been migrated to the Department of

Health Policy and Management. Dr. Richard Nugent serves as the Director of the Center for MCH Studies. //2007//

/2008/ Dr. Nugent continues to direct the COPH Center for MCH Studies. Four of the five courses taught as an MCH Department are planned for presentation in the 2007-08 academic year, two in the fall and two in the spring. The one course not taught was an overview of all the MCH courses. Student enrollment in these courses have not been large. When enrollment fell below 5 students for a course, it was taught instead as a directed study, still at 3 credit hours. Although the COPH budget has increased incrementally, most of that income is directed to public health research. However, as Tobacco dollars decline, and as funding support from UAMS for faculty and teaching does not increase, money is more scarce than ever before.//2008//

/2009/ With severe budget cutbacks for the College of Public Health, the full-time faculty position supporting the MCH Courses was discontinued, and its incumbent found other work. As a result the major faculty support for MCH Courses was lost. It is not anticipated that an MCH Course will be taught in the fall. Dr. Nugent will continue his appointment with the purpose of developing a 5-year plan to return the MCH presence in the COPH to departmental status. Meanwhile, he is devoting more time to assisting the ANGELS evaluation for the College of Medicine Department of OBGYN.//2009//

/2010/ Dr. Nugent participated at 10% supported time with a lead hazards awareness project called APPLE (Arkansas People to Prevent Lead Exposure). The Project, led by Alesia Ferguson, PhD of the Department of Environmental and Occupational Health, COPH, visited 5 communities with high proportions of low income people and old housing. The educational efforts targeted contractors to provide training and certification in Lead Safe practices, and parents to increase awareness of old and at-risk housing (peeling paint, contaminated yards, etc), and to seek medical help for blood lead screening if indicated.//2010//

/2008/ State/Local coordination in the organizational structure of the new ADH will remain the same. The five organizational units under the Executive Staff remain the same: the Centers for Local Public Health, Health Advancement, Health Protection, and Health Practice; and the State Laboratory. The Center for Local Public Health administers the Regions, Districts, and Local Health Units. Within the Center for Health Advancement the Family Health Branch (administering the MCH Block Grant) will relate even more closely to its sister Branches of WIC, Oral Health, Chronic Disease, Tobacco Control, and Life Stages. Together, more of the Centers' programmatic supports for local communities is being administered through grants to community lead agencies. //2008//

/2008/ With the effects of the influx of Hurricane Evacuees receding in time, local health unit efforts have returned more to a normal state. However, they continue to be involved in local planning teams for all-hazards emergency response, and with the Bioterrorism programs of the Center for Health Protection. //2008//

/2009/ In addition to the Executive Staff and Senior Staff meetings of the agency, two other forums exist to help Centers collaborate. The Scientific Advisory Committee develops and assures the use of the public health evidence base to support the assessment, policy and assurance functions of the ADH. Dr. Nugent serves on that group as Associate Director for Science with the Center for Local Public Health. Also, the Doctors' Horizontal Team provides links among agency medical professionals including physicians, dentists, veterinarians and other doctoral- level personnel. This year a "sister" Branch in the Center for Health Advancement conducted a major planning effort called the Chronic Disease Forum. Dr. Nugent attended events in that planning effort. In another change, Dr. Martha Phillips resigned as Director of the Center for Health Practice. The Executive Staff placed the State Health Laboratory under the Center for Health Practice, and appointed Dr. Glen Baker as Director for the Center as well as the Laboratory. //2009//

/2010/ Family Health conducted its Stakeholders meeting on May 13, 2009 for the Needs Assessment due in 2010. Dr. Namvar Zohoori from Chronic Disease participated, a "return favor" for Dr. Nugent's participation in the Chronic Disease Forum's strategic planning effort. Dr. Jennifer Dillaha, Center for Health Advancement Director led the Stakeholder group discussion. //2010//

CSHCN STATE AGENCY COORDINATION

In its relatively new location in the Division of Developmental Disabilities in DHHS, the Children's Medical Services (CSHCN) Program is working more closely with other programs for developmentally disabled children, and with Medicaid. Arkansas Medicaid's Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) is currently undergoing a revitalizing effort to increase screens through increased information sent to families and providers in mailings from the Medicaid contractor. These efforts should help increase EPSDT screenings. The Title V CSHCN staff routinely monitor the screens for the children and youth for which we are responsible for case management. When the EPSDT screening responsibilities were given solely to the Medicaid recipient's primary care physician, the ADH ceased providing the EPSDT services in areas of the state that were not medically underserved. Quite often, the screens are not billed as EPSDT and it is therefore difficult to monitor the periodicity rates and follow-up. New information systems are needed to track the completeness of child developmental assessment by Primary Care Physicians. The data system issues are unfolding slowly, but are being discussed in many circles, especially the Medical Home Committee of the Arkansas Early Childhood Partnership. The issue also arises during many discussions of the potentials for care coordination for children.

Especially active is another new collaboration closely related to the CMS program. Supported by a grant from HRSA called the Arkansas Early Childhood Care and Services (AECCS) Program, this new collaboration has a steering committee and subcommittees addressing Socio-emotional Development, the Medical Home, and Tiered Quality Services. These groups have begun to articulate recommendations in all these areas, and are moving to implement for effective partnerships in these areas. A statewide conference is being planned which will bring together educators, day care center operators, physicians, early childhood programs and especially parents to strengthen these relationships. Leaders from the Division of Health have also been active on these committees.

Within the former Department of Human Services there has been an important "division of labor" to accomplish the case management needed by many CSHCN families. The 4 CMS nurse coordinators covering the state have heretofore targeted their efforts to supporting families who did not have Medicaid among whom are many that have very little health insurance. There are a much larger number of DHS case-managers who can provide these enabling services to families who do have Medicaid coverage. By this plan, all 26 areas of the state can be covered with case management services.

/2009/ Nancy Holder, Program Administrator for the Title V CSHCN program, now serves on the Executive Council of the Child and Adolescent Service System Program (CASSP) with the merging of the Together We Can and CASSP programs, effective 7/1/08. She is also a member of the ABCD Stakeholder's Group, the AR Kids Count Finish Line Coalition and the Oral Healthcare Advisory Committee. She attends the Governor's Roundtable on Healthcare as an interested observer. The Title V CSHCN Parent Coordinator, Rodney Farley, is active in Family Voices, serves as Chair of the UAMS Partners for Inclusive Communities Consumer Advisory Council, serves on the Parent as Educators Advisory Committee at AR Children's Hospital, serves as a board member of the AR Disability Policy Consortium. //2009//

/2010/ The CSHCN Program Administrator is actively working with two workgroups on Medical Home. First is the Dept of Human Services Medical Home workgroup spearheaded

by Medicaid. The initial project is aimed at better serving Foster Children in a Medical Home utilizing Electronic Health Records. Second is the Medical Home workgroup with the Arkansas Early Childhood Comprehensive Systems program. Dr. Richard Nugent co-chairs this workgroup. In addition, the Program Administrator works actively on the DHS Policy Workgroup whose current project is looking at cultural competence activities within the Department and training needs in that area. Rodney Farley, Title V CSHCN Parent Coordinator, displayed information on CSHCN resources at the Arkansas Department of Special Education Special Show providing information to several hundred teachers and agency personnel. He serves as Chair of Consumer Advisory Council for Partners for Inclusive Communities (AR UCEDD). He is a board member of the following councils: CAN DO (promotes perspectives of youth and adults with disabilities); Arkansas Disability Policy and Consortium; and the Disability Rights Center. He serves as Regional Coordinator for Family Voices, as well. He is a member of the Arkansas Parents as Educators Advisory Committee at AR Children's Hospital and the Transition committee at the Arkansas Department of Special Education. //2010//

F. Health Systems Capacity Indicators

Introduction

/2010/ Health Systems Capacity Indicators primarily assess, in a general fashion, how well state programs such as Medicaid, SCHIP, and CSHCN are meeting the needs of those eligible for such services. They also assess Title V programs' ability to access relevant data sources and linkages. While CSHCN data are quite accessible to the Arkansas program, Medicaid and SCHIP data require a formal request through the Medicaid agency (housed in Department of Human Services). As noted for several of the HSCI's and performance measures, certain Medicaid figures for 2008 seem somewhat inconsistent with prior years, in the absence of any known program or eligibility changes that would account for the discrepancies. At this point it is uncertain if certain measures have actually worsened during the past year, or whether queries in use are not capturing the desired information. Further discussions with Medicaid data and administrative staff should help clarify the situation and produce more reliable figures in future years. //2010//

Health Systems Capacity Indicator 01: *The rate of children hospitalized for asthma (ICD-9 Codes: 493.0 -493.9) per 10,000 children less than five years of age.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	27.4	26.9	22.3	22.3	23.7
Numerator	508	504	430	430	471
Denominator	185555	187377	192891	192891	198977
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008

Data source: Hospital Discharge Data System, Health Statistics Branch, ADH.

2008 indicator pre-populated with 2007 data, as 2008 Hospital Discharge data is not available.

Notes - 2007

2007 indicator pre-populated with 2006 data, as 2007 Hospital Discharge data is not available.

Notes - 2006
2005 population estimate 0 - 5 years used for 2006 indicator

Declines in admissions of children for asthma are consistent with a statewide public awareness campaign called "Don't Let Asthma Slow You Down," and a parallel professional education campaign about the usefulness of adding anti-inflammatory medications to regimes of bronchodilator inhalation therapy for symptomatic asthma, and awareness of the need for medical care for this common disease in childhood. These efforts began at least 4 years ago with a major initiative of the AFMC (Arkansas Foundation for Medical Care - the state's Professional Review Organization)

Narrative:
Professional education, and public awareness messages on TV entitled ("Don't let asthma slow you down"), have spread knowledge of the value of steroidal and other anti-inflammatory inhalers for the management of asthma. It is better known that bronchodilators only treat one aspect of the complicated patho-physiology which leads to symptomatic asthma. Environmental knowledge about roach infestation and its relation to asthma in children has also received attention in Arkansas. The State Systems Development Initiative grants over the years have added immeasurably to the Center for Health Statistics' ability to link important databases for vital records, hospital discharge, PRAMS, and BRFSS. This linking has been especially informative to the MCH Block Grant monitoring process for other specific indicators which will be discussed with those indicators.

/2009/ Hospital discharge data files will not be finalized until late July. As a result, we have "prepopulated" the data reported above with information from last year.//2009//

/2010/ Asthma hospitalization rates for young children in Arkansas appear to have declined somewhat, particularly from the 33.5/10,000 figure reported in 2003. Compared to a national figure of 50.7/10,000 for children 0-4 for the years 2004-06 (CDC hospital discharge surveillance system), Arkansas appears at first glance to be ahead of some states in this regard. However, a less optimistic interpretation is that some young children in the state who actually have asthma are being misdiagnosed, hospitalized, and treated as cases of "pneumonia" or "bronchitis." Anecdotal reports from tertiary care center medical staff (who routinely accept such patients as transfers from smaller hospitals) suggest at least some plausibility for the latter hypothesis. If true, continued medical education directed at primary care providers is the most logical solution, and this is indeed being pursued through the UAMS Department of Pediatrics and the state Medicaid agency, along with other groups. //2010//

Health Systems Capacity Indicator 02: *The percent Medicaid enrollees whose age is less than one year during the reporting year who received at least one initial periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	63.2	63.2	75.2	75.5	61.8
Numerator	15932	15932	20544	22003	19915
Denominator	25225	25225	27311	29146	32205
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
Data source: FY 2008 Medicaid claims.

Since 2006, through collaboration with the Medicaid Division of the Arkansas Department of Human Services, the ascertainment of numerator and denominator numbers has improved.

Notes - 2007
Data source: FY 2007 Medicaid claims.

Since 2006, through collaboration with the Medicaid Division of the Arkansas Department of Human Services, the ascertainment of numerator and denominator numbers has improved.

Notes - 2006
Data source: FY 2006 Medicaid claims

AR Kids First program expansions on Medicaid are reaching more children.

Narrative:
/2008/ On the surface it is encouraging to see the indicator for access of enrollees to primary care improving. However, this indicator continues to be somewhat complicated in Arkansas. As leaders of the MCH Block Grant, ADH personnel do not have a "clear line of view" into how these data are generated. Physicians' offices have a variety of ways in which they fulfill Medicaid's expectations for "periodic screens" and "developmental assessments," as distinct from an episodic visit. The development of the Medical Home in Arkansas was initiated through two activities: 1) a residency training module for pediatrics and family practice on the subject at UAMS, and 2) regional talks throughout the state given by the prior Medical Director for Children's Medical Services. His replacement, a sub-specialty boarded developmental pediatrician at Arkansas Children's Hospital has also provided this education. The residency training program has been producing physicians who are well aware of the concepts and ideals of the Medical Home, yet the process of actually carrying them out in practice, including effective screening techniques for developmental assessment, has not been standardized in Arkansas. The Area Health Education Centers' Regional Medical Program regularly sponsors CME sessions on a variety of topics, one of which has been the Medical Home; however, the degree to which this training has resulted in changes in practice can not be well measured from our database. Medicaid can count the number children for whom an EPSDT visit was paid for, or the number of initial visits for children once enrolled in Medicaid, but these are rough tools, and inadequate to gather the information needed to assess the characteristics of care given. Toward this end, Arkansas is participating in a program called the "Assuring Better Child Development" (ABCD) technical assistance opportunity sponsored by HRSA. A team of state child health leaders, including Medicaid, Health, Child Care and Early Childhood Education, the Child Development sub-specialist at Arkansas Children's hospital, and the executive staff person of the Arkansas Chapter of the American Academy of Pediatrics have formed a "core team" in anticipation of attending this national technical assistance opportunity. A support group including a wide variety of health and social services leaders has been gathered in anticipation of the return of the Core Team to begin coordinated planning. Bright Futures, the Academy of Pediatrics' new guidance in this area, and the results of pilot projects in North Carolina, Vermont and elsewhere, will be utilized in this technical assistance opportunity.

/2009/ Data on receipt of an EPSDT "periodic screen" shows an increase in both numerator and denominator numbers consistent with growth in the enrollment for AR Kids A and B (Medicaid and SCHIP). The percentages of children receiving a periodic screen are consistent and even

showing a slight increase. This represents better data than previous years. The improvement in the data and the slight increase reflects a strong involvement by the Medicaid Program in following this measure. Medicaid contracts with the Arkansas Foundation for Medical Sciences (AFMC), formerly the PRO, to have its employees make annual visits to most Medicaid Primary Care Physicians with the emphasis on those providing care for children. Functioning like "detail agents" for pharmaceutical and formula companies, these workers make contact with doctors and their office personnel to explain Medicaid programs and provide technical assistance with billing and policy issues. AFMC staff are now actively involved supporting two pilot projects in physicians' offices to apply the Ages and Stages Questionnaire (ASQ), a validated and popularly used tool for general developmental screening. Currently, with the help of the AFMC staff and Medicaid, the Assuring Better Child Development (ABCD) planning group is starting on a "Statewide Spread Strategy" to extend developmental screening by a validated tool to 30 or more Primary Care Physicians' offices in the next year. Medicaid has further detailed its billing codes to provide specific reimbursement for these services.//2009//

/2009/ The ADH, with major collaboration from the DHS, especially its planners and leaders for Behavioral and Early Childhood Education Divisions, made application to the Project LAUNCH grant program, a joint effort of SAMHSA and HRSA (MCHB). This grant envisions creating an Early Childhood Partnership Council, and will be working with a pilot project in the town of Stuttgart in Arkansas County. The Family Physician there, Dr. Dennis Yelvington, is now one of two practices implementing the Ages and Stages Questionnaire for developmental assessment, as a pilot for the Assuring Better Child Development initiative. That practice will add the Socio-emotional scale in ASQ.//2009//

/2010/ While the number of infants receiving Medicaid services increased in 2008, the number and percentage receiving even a single EPSDT screen decreased. More work is needed to ensure infants receive preventive services. Unfortunately, AR Medicaid has postponed implementation of reimbursement for developmental screening. Although last year's application for Project LAUNCH was not funded, ADH and DHS have again collaborated on an application for FY2010 funding. //2010//

Health Systems Capacity Indicator 03: *The percent State Childrens Health Insurance Program (SCHIP) enrollees whose age is less than one year during the reporting year who received at least one periodic screen.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	8.0	8.0	61.4	62.7	17.6
Numerator	66	66	522	602	165
Denominator	823	823	850	960	939
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008

Data source: FY 2008 Medicaid claims

Then number of children less than one year who have received at least one periodic screen in 2008 is difficult to accept based on previous years' data. We are currently attempting to communicate with the Medicaid Program to ask about double checking this number or providing

an explanation of why the number is so much lower that previous years' numbers. As of this date, we have not been able to obtain this information.

Notes - 2007
Data source: FY 2007 Medicaid claims

Since 2006, through collaboration with the Medicaid Division of the Arkansas Department of Human Services, the ascertainment of numerator and denominator numbers has improved.

Notes - 2006
Data source: FY 2006 Medicaid claims

ADH staff continue to seek better information from Medicaid's data contractor. Collaborative efforts have again improved this year, so we hope to have clearer information in the coming years to really evaluate this trend.

Narrative:
/2008/ As with other indicators of this nature, ADH MCH leaders continued to have questions about how this data was gathered and assessed. Conversations with Medicaid's data contractor, EDS had begun in which a more detailed understanding of this information is being sought. At least two ways of arriving at this information occur in Arkansas: 1) EDS can produce the information on the % of enrollees under age 1 (either Medicaid or SCHIP) who have had a billed and paid EPSDT visit. This still leaves ADH unclear about what has been accomplished during those billed visits. 2) Perhaps a more detailed look had been made by the Arkansas Foundation for Medical Care as the Physician's Review Organization for the state. AFMC has access to physicians' office medical records. AFMC accesses a sample of records from medical offices and queries those records for the assessments required by EPSDT in their developmental assessments. In years 2004 and 2005, the AFMC data was reported above. In the years 2003 and 2006 the EDS data have been reported. Neither one, in our view, fairly reflects the services given to Arkansas's children. Perhaps Arkansas's planned attendance at the ABCD national technical assistance opportunity will begin to lay the groundwork for widespread communication with the state's doctors about these services.

/2009/ As with HSCI # 2, ascertainment of periodic screen information has improved. This can be seen from the consistent data reported for 2006 and 2007. A detailed explanation given for HSCI # 2 applies to this indicator also. A new Project LAUNCH application envisions working with the Assuring Better Child Development initiative (statewide spread using the Ages and Stages Questionnaire for child development assessment) to extend the effort to include the Socio-Emotional Scale. //2009//

/2010/ Although number of total enrollees in SCHIP <1 year of age (the denominator) has remained fairly constant for the past several years, the numerator for 2008 is incongruent with that from the prior two years, for no easily discernible reason. AFMC continues to have workers regularly visit primary care physicians' offices to inform them of Medicaid services and the recommended periodicity of well-child visits, among other items. Through parent newsletters, phone calls, and other avenues, the Health Connections Section within Family Health continues to encourage parents to take their infants and children for routine checkups. Lacking any other plausible explanation for the large drop-off in 2008, further discussions with the Medicaid data unit to clarify methodology for computation of the numerator must ensue. //2010//

Health Systems Capacity Indicator 04: *The percent of women (15 through 44) with a live birth during the reporting year whose observed to expected prenatal visits are greater than or equal to 80 percent on the Kotelchuck Index.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Indicator	80.0	79.0	79.1	81.0	80.3
Numerator	30353	30755	31697	33425	32969
Denominator	37956	38937	40061	41248	41046
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
Data source: Health Statistics Branch, ADH

These data are reported for October 1, 2007 through September 30, 2008.

Notes - 2007
Data source: Health Statistics Branch, ADH

These data are reported for October 1, 2006 through September 30, 2007.

Notes - 2006
The small, but very persistent trend for this indicator to get worse is of concern to the MCH folks and the ADH Director. It is consistent with a small but steady and presistent trend to see fewer pregnant women in our Local Health Unit prenatal clinics. The apparent changes are quite uniform among the regions in the state, so we believe they are a consequence of something pretty widespread in our socio-economic environment. As we prepare for the coming 5-year needs assessment, this issue will be discussed with our stakeholders to determine how best to address it.

Narrative:
The Kotelchuck Index uses three fields from the birth record of each baby: the date of the last menstrual period, the number of prenatal visits (and when they started), and the date of birth. It attempts to measure the amount of prenatal care the mother received recognizing that for a premature baby (for example, one born before 37 weeks) the mother could not have had the last weekly visits for weeks 37, 38, 39 and 40. The index calculates the number of visits reported on the birth certificate as a percentage of the vists expected for the length of gestation. Thus an index of 80% means that the mother had 8 visits if her pregnancy lasted long enough to cause an expected 10 visits. The expected visit number is taken from the ACOG recommended schedule of visits to occur each month for the first 7 months (to 28 weeks), then every two weeks through the 36th week, then evey week until delivery. The number above represents the average Kotelchuck Index for all births in Arkansas. Note that among all births, the Kotelchuck Index score is declining slightly but very steadily. It is not yet clear what this trend indicates. At this writing, we have not looked at the trend by race. However, we have noticed that the numbers of women served in our local health units has been flat, or shown a very slight decline.

/2008/ The Arkansas Department of Health continues efforts to improve the health of mothers and babies. ADH's role is to ensure all women in Arkansas have access to adequate prenatal care. Local health units in 57 counties provide prenatal services. The county health units work with the other health care providers in the community to ensure pregnant women have access to early prenatal care. Clients are provided referral information and accessibility to other ADH services, such as WIC and Immunizations. Designated Local Health Units determine presumptive eligibility

(PE) of pregnant women for limited Medicaid benefits for outpatient prenatal care. Arkansas Medicaid can be granted for women up to 200% of the federal poverty level. Arkansas Medicaid also provides coverage for undocumented pregnant women under SCHIP (State Children Health Insurance Program). This is known as the "unborn child" provision. Births to Hispanic women number about 3300 in Arkansas each year.//2008//

/2008/ A strong effort has been made to recruit and retain nursing staff to fill the shortages in the local health units. Colleague orientation to MCH programs provides new nurses a greater understanding and improved abilities. //2008//

/2008/The Campaign for Healthier Babies provides a coupon book designed as an incentive for pregnant women to obtain and continue prenatal care. Advertising efforts include media (radio and television and web sites), promotional flyers in doctors offices and public health units and a 24 hour telephone access help line. The Campaign provides for Medicaid participant outreach and education to facilitate enrollment, primary care physician selection and use of preventative services. On a cumulative basis, over 220,000 Arkansas Women have used to the Happy Birthday Baby Book to help them have a have a better pregnancy. The HBBB was updated this year. //2008//

/2009/ The Center for Local Public Health has made vigorous efforts, with the support of the Women's Health Section, to increase its services to pregnant women. The ADH quality assurance review system tracks numbers of maternity patients served to monitor productivity. A small dip in numbers served in the last year was of concern, which has since reversed. The observed improvement in the Kotelchuck Index statistics reported above for this latest year is encouraging in the light of that effort. More emphasis is being placed on the use of reminder and recall systems in women's health, especially Family Planning. The Regional Director's Office in each of the five Public Health Regions has paid especial attention to productivity of staff in maternity clinics.//2009//

/2009/ Governor Beebe has expressed an interest in reducing both teen pregnancy and infant mortality. The Center for Local Public Health and the Family Health Branch have collaborated in proposing a variety of community based special project ideas. These center mainly around enhancing clinical staff (circuit riding teams) to address gaps in capacity for family planning and prenatal clinics, and enhancing wraparound services such as family planning care coordination, reminders and recalls, and community-based recruitment efforts.//2009//

/2010/ The Center for Health Advancement and the Center for Local Public Health (CLPH) continue efforts to increase services to pregnant women in the local clinics and provide referrals to Medicaid providers. The number of women served for maternity has decreased this year but ADH Regional Directors are focusing on enrollment in pregnancy Medicaid and collaborative efforts with local DHHS offices. Two Northeast Region family planning traveling teams to increase family planning services in six counties have been funded by Title X. Local health units continue to use appointment reminders by using a statewide system based in the CLPH. A total of 13,003 Healthy Baby Happy Birthday Baby Books were provided to Arkansas's pregnant women.The Health Connections Section through a ConnectCare contract with Arkansas Medicaid works to connect Arkansas Medicaid recipients to healthcare providers and health resources.//2010/

Health Systems Capacity Indicator 07A: *Percent of potentially Medicaid-eligible children who have received a service paid by the Medicaid Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	79.5	98.5	85.0	97.2	97.2
Numerator	320430	450332	345512	464845	464845

Denominator	403245	457214	406494	478052	478052
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
2008 indicator is prepopulated with 2007 data due to inability to obtain this information from the Medicaid Program.

Notes - 2007
2007 rate is percent of Medicaid enrollees who have received a service paid for by the Medicaid Program.

Notes - 2006
As MCH Director, I am not sure why these data are inconsistent. We are working more closely with our Medicaid partners to sort this out.

Narrative:
As with other indicators from Medicaid claims information, ADH staff do not have a "clear line of sight" into the way in which this data is collected, and why it might vary as it apparently does from the above numbers. However, conversations with data managers from EDS, Medicaid's data contractor, have strengthened in the last year, and we hope to have more detailed understandings in the near future. Also, as reported for other indicators, Arkansas is going to attend the ABCD technical assistance workshop to begin a statewide plan regarding ways to enhance services to children for routine periodic care, preventive services, and developmental assessments.

/2009/ The 2007 data presented above, as with other Medicaid counts of services appearing in this '09 application, shows increases in number served consistent with increases in enrollment. The 97.2 percent of enrolled children served is now more consistent with measures from 2003 and 2005. We believe that this data is better ascertained and reported from Medicaid files, and are reassured that enrolled children are actually seeing their primary care physicians. The Connect Care effort, contracted to the ADH and residing in the Health Connections Section of Family Health, has increased its efficiency in contacting new enrollees and setting up initial appointments with primary care physicians. The added "case management" active attempts to get newly enrolled children an appointment with a dentist are going well, and may be helping to add completeness to enrolling children with physicians. Medicaid is joining with multi-agency state planners through the Early Childhood Comprehensive Systems collaborative and in so doing has paid greater attention to physician practices in the service of low income children. Children in both the "EPSDT level" (AR Kids A) and "SCHIP level" (AR Kids B) of Medicaid services benefit from these efforts. //2009//

/2010/ Data for 2008 were not available, but the percentage of Medicaid children receiving a service that year is unlikely to have changed substantially compared to 2007. Children enrolled in Medicaid are definitely utilizing the services available to them. With recently legislated expansion in income eligibility limits, an additional 15,000-20,000 children could be added to the total receiving benefits over the next one to two years. The Health Connections Section has continued outreach efforts to promote enrollment, as well as to ensure recipients get linked to primary care providers. //2010//

Health Systems Capacity Indicator 07B: *The percent of EPSDT eligible children aged 6 through 9 years who have received any dental services during the year.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	41.0	42.7	43.6	46.5	38.8
Numerator	30827	38842	34517	37557	47915
Denominator	75151	90958	79094	80681	123588
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
Data source: FY 2008 Medicaid claims.

Notes - 2006
Fewer providers were accepting Medicaid in FY 2006.

Arkansas is working on this problem in several ways:

1) The Oral Health Program conducts a pubiic and professional awareness campaign every year. The Program also involves dentists in performing oral examinations on third grade children.

2) The Children's Medical Services staff work hard with their families to get more dental services for their enrolled children.

3) The Health Connections Section is now providing case management for new AR Kids First (and other) clients to get them appointed to a dentist's office as a new client. This effort is now just getting mounted, so when 2007 data are obtained, we should see some impact there.

Narrative:
The data above express the trend toward increased dental services among EPSDT (Medicaid, AR Kids A) children. A great deal of effort has gone into improving this trend. In the last few years, Medicaid has again increased fees to dentists, Dr. Lynn Mouden of the ADH has actively developed the oral health program in the state, and he has involved more and more dentists in voluntary efforts to screen third grade children for dental sealants and other evidence of care. The Oral Health Program conducts a Governor's Summit evey summer which attracts a large attendance of dentists, dental hygienists, and other health professionals. In addition, Dr Mouden has visited many communities to urge the fluoridation of water supplies. There are many communities in Arkansas whose water still lacks fluoride, and the opposition to this change has been vocal. That fluoridation of public water supplies has, time and again, been proven safe, effective, and inexpensive, seems not to deter this opposition. Also, the Health Connections Section of the Family Health Branch has, under a new contract with Medicaid, added staff to help new Medicaid enrollees, both women and children, get first visits with a dental provider. Much oral health information is available through the Connect Care Hotline operated in the Health Connections Section. Probably most effective, however, has been the Oral Health partnership with Children's Medical Services and with Head Start Programs where children are strongly encouraged to receive dental care, and where insurance resources can be sought out to cover these low income kids.

/2009/ The added efforts of the Health Connections Section, as supported through a contract from Medicaid, continue to build. Health Connections Staff contact parents of newly eligible children in AR Kids A (Medicaid) and AR Kids B (SCHIP), identify a nearby dentist and arrange appointments for the child. Then the staff person follows up to see that the visit occurred. Reminders and recalls are applied. The increase from 43.6 to 46.5 percent of children receiving dental services is encouraging. //2009//

/2010/ Since the denominator changed so dramatically in 2008 (without any expansion in Medicaid eligibility that year), the apparent decrease in percentage of children served may reflect differences in Medicaid tabulation methodology rather than a true decline. Health Connections staff continued aggressive efforts to arrange dental appointments, issue reminders, and ensure appointments were kept. Oral health has been designated a high priority within the Department of Health, particularly for children, but there remain many counties in the state with insufficient dental providers to meet the needs. //2010//

Health Systems Capacity Indicator 08: *The percent of State SSI beneficiaries less than 16 years old receiving rehabilitative services from the State Children with Special Health Care Needs (CSHCN) Program.*

Health Systems Capacity Indicators Forms for HSCI 01 through 04, 07 & 08 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	43.2	40.5	44.7	51.1	36.8
Numerator	7411	7427	8658	10066	7410
Denominator	17155	18344	19382	19714	20143
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008

There has been a readjustment downward in the numerator to levels similar to 2004 and 2005. Cases are placed in an inactive status if there is no response from the family after repeated contacts in an attempt to better reflect current activity.

Notes - 2007

2007 data: renewal of relationships with families of CSHCN covered by SSI has led to an increase in this indicator in the past 2 years.

Notes - 2006

SSI Beneficiaries have among them a number of children who need rehabilitation services and are cared for by Children's Medical Services. One way to increase the percentage of children in need receiving those services is the availability of case managers for the CSHCN population. With reorganization of the CMS Program into the Division of Developmental Disabilities' Services, and attention from the Director of that Division allowing CSHCN case managers more time to follow these children, we may see some increase in this measure. 2006 information seems to support that supposition.

Narrative:

A slight increase in the numerator and the annual indicator is the result of services provided to applicants for the Title V Family Support/Respite program, a large number of whom were previously not known to the CSHCN program.

Health Systems Capacity Indicator 05A: *Percent of low birth weight (< 2,500 grams)*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of low birth weight (< 2,500 grams)	2007	matching data files	10.2	7.1	8.9

Notes - 2010
Data source: provisional 2007 linked birth certficate / Hospital Discharge Data System files.

Narrative:
LBW is one of the leading risk factors for infant mortality and morbidity and continues to require additional effort to address. Nationally, LBW accounts for 60% of all infant mortality. Overall, the rate of LBW in AR for 2004 was 9.3%, over one percent higher than the national average level. The HP2010 Objective (16-10a) is to reduce LBW rate to 5.0%. Evidence suggests an association between low birth weight and prenatal care, especially first trimester care that continues until delivery. Women in high-risk categories often do not seek early prenatal care. Early prenatal care for low-income women is dependent on availability, accessibility and affordability. March of Dimes data reported during 2001-2003 (average), about 1 in 5 women of childbearing age in Arkansas were living in amilies with incomes below the Federal Poverty Level. One in 4 women of childbearing age are uninsured. The proportion of women in poverty and uninsured women are significantly higher than the national average level.

/2008/ Comparing the above percentages to what was reported in this application for 2003, the Medicaid low birth weight rate increased from 9.7 to 10.0, while the non-Medicaid low birth weight rate decreased from 7 to 6.7. The rate for "all" births increased from 8.3 to 8.6 because 55% of all births in Arkansas are paid by Medicaid, so the total tracks with that population. While the rate difference for these two subgroups is not startlingly different for the compared years, and may just be year-to-year variation, these trends are in accord with rising national trends in low birth weight rates for African American babies, while those for Caucasian babies have declined. This evidence of increasing disparities is of concern, especially because of the great efforts to correct these trends through Medicaid expansions of eligibility. Those expansions included 1) pregnant women to 200% of poverty accomplished several years ago, 2) infants to 200% of poverty accomplished with the development of AR Kids First including SCHIP for infants, and 3) the inclusion of immigrant mothers in prenatal coverage through the "unborn child provision" in the Medicaid State Plan. The State's rates for early and complete prenatal care have also gradually slipped since regular increases peaked about two years ago.

/2008/ An interesting contrast of data is beginning to appear. The total percentage of children in poverty appears to be declining in Arkansas. So does the total percentage of children without health insurance. Additionally, teen birth rates are declining. One would expect that these changes would "place downward pressure" on low birth weight, preterm, and infant mortality rates. The total percentages, however, tend to hide what is happening to the lowest socio-

economic subgroup. When African American births are looked at, the disparities in low birth weight, preterm birth and infant mortality are widening. Although the explanation for these findings is not yet clear, one wonders if life situations linked mostly to African American citizens, that are additional to poverty (cultural), are at work. For public awareness, patient education, and community based activities to be enhanced, health care leaders should be increasingly attending to cultural awareness in the provision of these services.

/2008/ The Campaign for Healthier Babies continues to provide a coupon book designed as an incentive for pregnant women to obtain and continue prenatal care. Over the years since initiation of the service, over 220,000 Arkansas Women have used the Happy Birthday Baby Book to help them have a better pregnancy. ADH maintains a resource referral directory, available by a toll free number, to provide information for the public, providers and the local health units. The Health Connections Section of the Family Health Branch, operates a hotline to support the Healthier Baby public health spots, and allow a place for a pregnant woman to obtain the Happy Birthday Baby Book (containing health information), as well as names of doctors and other providers of services relevant to pregnancy and childbirth.//2008//

/2009/ All the above efforts continue. The trend on teen birth rates has ceased its decline, and it appears that LBW trends are continuing upward. Arkansas is concerned about these indicators. Arkansas's new Governor, Mike Beebe is interested in teen pregnancy and infant mortality and has asked ADH to propose some new special projects. A variety of types of activities have been discussed within ADH, particularly between the Family Health Branch and the Center for Local Public Health. Most of these ideas center on several community-based projects aiming to build clinic capacity where needed, and to add care coordination and outreach to support family planning and prenatal clinics. (See comments under HSCI # 04.) //2009//

/2010/ All efforts mentioned above continue as does the trend upward for LBW. Targeting LBW babies as a major contributor to infant mortality is a strategy being given more consideration. This has come to the attention of the Governor, the Dept. of Health and its many partners around the state. The Dept. of Health has made decreasing infant mortality one of its primary objectives in it's Strategic Plan. An Infant Mortality Action Group made up key health organizations has come together to identify, advise and/or execute activities that include reducing LBW to reduce infant mortality. //2010//

Health Systems Capacity Indicator 05B: *Infant deaths per 1,000 live births*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Infant deaths per 1,000 live births	2007	matching data files	7.3	5.4	6.5

Notes - 2010
Data source: provisional 2007 linked birth certficate / infant death / Hospital Discharge Data System files.

The 2007 data are lacking births/deaths that occurred to Arkansas residents in other states. Interstate exchange agreements between states guarantee birth/death certificates to Arkansas from other states, but the process may be prolonged.

In addition, infants born in Arkansas that have a high probability of dying (i.e., very low birth weight, multiple congenital anomalies, etc.) are followed up to determine if the infant did indeed

die. This is a lengthy process.

These two circumstances above may ultimately result in a higher infant mortality rate than is reported for 2007.

Narrative:
The Arkansas Medicaid Program pays for the birth hospitalizations of 55% of all babies born in the state. Though a majority, they contain, by financial eligibility rules, nearly all births to low income families in the state, and as such, have higher concentrations of minority and immigrant births. Thus it is not surprising that infant mortality rates are higher in Medicaid. The data presented above are taken from linked birth/infant death files which in turn are matched to Medicaid records. This special study file shows the death rate for "all" births at 7.1. This represents a decline from 7.3 as reported on Form 18 for 2003. However when the individual birth groups are examined, the Medicaid rate went from 7.8 in 2003 to 8.2 in 2005, while the non-Medicaid group went from 6.6 to 5.3. While these differences may not be alarming because of year-to-year variations in these rates, this finding is consistent with trends in race-specific infant mortality rates in which the African American to Caucasian infant mortality ratio has been increasing. Significant and steady increases in low birth weight rates, and in preterm births, observed in both Arkansas and the US, which are also increasing in disparity, lies behind this trend. These changes are broad-based in cause (not just due to Assisted Reproductive Technology) because even singleton live births are increasing in these risk factors. That infant mortality, over all, has not risen, probably speaks to the efforts over the last few year to get more mothers covered with Medicaid (increasing eligibility to 200% poverty and the implementation of the 'unborn child' provision in SCHIP), and to assure that unwanted pregnancies are prevented as reliably as possible (Family Planning Waiver). It may also be due in part to the decline in teen births both as a fraction of all births, and in teen birth rate. Increases in elibility for all children up to 18, includes teenagers in its positive impacts, also leading to increased care for pregnant teens. Finally, review of ANGELS evaluation data shows that birth weight specific infant mortality rates at under 1500 grams and under 1000 grams continue to improve.

/2009/ Concern about continuing high rates of low birth weight go on apace. The discussion above still applies. The program is expecting, when final infant death data become available, (perhaps before this application is submitted) that Arkansas may see a rise in infant death rate. If that happens, ADH will take a detailed look at all the risk factors related to infant death to determine the most appropriate actions to address the problem.//2009//

/2009/As part of the ANGELS evaluation, Dr. Kande Ananth, an epidemiologist from New Jersey, has pointed out that Infant death rates among Arkansas Medicaid births who are late preterm and have birth weights in the 2000 to 2500 gram range are disproportionately higher compared to non-Medicaid births in the same weight range; while other birth weight ranges show more comparability between Medicaid and non-Medicaid births. To date this finding has not had a lot of discussion neither in Arkansas, nor in the national literature. Arkansas's interpretation is that the very low birthweight babies suffer from medical complications that are serious enough to outweigh the effects of socioeconomic disparities, and are well served by perinatal intensive care. Thus in the higher birth weight categories the S-E disparities are more evident. The thought offers another effort to address the disparities issue -- community based, culturally sensitive, special projects to enhance capacity of prenatal and family planning services, and enrich them with wraparound services such as care coordination and recruitment. (See discussions in HSCI # 4.) //2009//

/2009/ Dr. Nugent reviewed infant mortality data for Arkansas, presented it at ADH Grand Rounds last spring, and, last summer, presented to a retreat of County Health Officers, attended by well over half of those physicians who serve as "County Health Officers". During that presentation he emphasized Prematurity, Birth Defects and SIDS. Interventions cited as worthy of consideration

included preconceptional health for young women, folic acid tablets as dietary supplementation to prevent neural tube defects, and Back-to-Sleep campaigns in communities with high minority populations where stomach-lying is still the rule rather than the exception. All of these interventions would profit from the development within ADH of social marketing capabilities, and funds to contract with community entities to enhance local planning and activities. Subsequent discussions of potential new projects within ADH have also taken this perspective into account. (See discussions under HSCI #s 05A and 4.)//2009//

/2010/ Despite the provisional nature of 2007 data, the size of the decrease gives us confidence that the infant death rate decreased considerably, suggesting that the efforts put forth over the last several years are having an impact. This decrease coincides with the decrease in the teen birth rate as well and the many other efforts in the state, such as the now mature high risk maternity program ANGELS. The Dept. of Health has made the reduction of infant mortality one of its primary objectives in its Strategic Plan. In addition an Infant Mortality Action Group made up key health organizations was formed to focus on this issue.
//2010//

Health Systems Capacity Indicator 05C: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester	2007	matching data files	68.8	89.4	77.6

Notes - 2010
Data source: provisional 2007 linked birth certficate / Hospital Discharge Data System files.

Narrative:
Additional to the above, data for women seeking prenatal care with their local public health units for CY2006 found 55% (2782/5009) initiated prenatal care during their first trimester. However, 9.5% (480/5009) of pregnant women seen at the local health units waited until their third trimester to begin prenatal care. This information again reflects differences between those who use the public health system and those who are able to access private care.

/2008/The information given above, showing 79.8 percent of births with prenatal care beginning in the first trimester, is down slightly from 80.4% reported for 2003 in a prior application. These two data points are comparable in trend to that among all birth certificates. In the unmatched data trend presented in National Performance Measure 18, the trend is slightly but steadily down over the years of 2003 to 2006. Returning to the above information, the Medicaid births show an early prenatal care rate of only 72% in 2005, down slightly from 72.2% in 2003, while non-Medicaid births show a rise from 87.7% to 89.8% in 2005. Again, we see trends that lead toward greater disparity, not less. So far, prenatal care, low birthweight, and infant mortality are all showing widening disparities, despite programmatic efforts to head off these trends.//2008//

/2009/ Please see comments shared for previous HSC indicators. The indicator for first trimester care seems better, but LBW and IMR trends continue to be worrisome. //2009//

/2010/ The Department of Health continues the provision of maternity services in 61 Local health Unit sites in 55 counties. For CY2008 the local health units provided initial maternity visits to 4768 women. Of those, 59.4% initiated care during the first 13 weeks of pregnancy. Regarding insurance coverage for ADH maternity clients, 70.7% had Medicaid, 21.7% were uninsured, only 1.3% had private insurance, and the remaining 6.3% had unknown insurance status. //2010//

Health Systems Capacity Indicator 05D: *Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])*

INDICATOR #05 ***Comparison of health system capacity indicators for Medicaid, non-Medicaid, and all MCH populations in the State***	**YEAR**	**DATA SOURCE**	**POPULATION**		
			MEDICAID	**NON-MEDICAID**	**ALL**
Percent of pregnant women with adequate prenatal care(observed to expected prenatal visits is greater than or equal to 80% [Kotelchuck Index])	2007	matching data files	73.3	80.8	76.5

Notes - 2010
Data source: provisional 2007 linked birth certficate / Hospital Discharge Data System files.

Narrative:
The Kotelchuck Index uses three data fields from birth certificates: last menstrual period date, number of prenatal visits, and the date of birth. It then compares the number of reported visits in relationship to the number of visits the mother could have attended according to the length of her pregnancy. The Index attempts to control for the fact that mothers who deliver at or before 36 weeks (for example) could not have had the last 4 expected prenatal visits. So a Kotelchuck index of 80% means that the mother actually received (according to birth certificate data which has some limitations here) 80% of the visits she could have been expected to receive, given her date of delivery. It also creates categories of "inadequate care," "intermediate care," "adequate care," and an extra care category which is taken to mean that the mother had many more visits than expected, probably because she had a medical complication of pregnancy requiring the extra visits.

/2008/Note that again, the Medicaid births show a lower average Kotelchuck Index score than non-Medicaid. Compared carefully to low birth weight and infant mortality, this difference is not so striking. The reason is that the effect of preterm birth has been controlled in the Index comparison. None-the-less, comparing these data points to 2003 data, the Medicaid Kotelchuck score of 70.7% in 2005 represents a decline from 73.8 in 2003, while the non-Medicaid Kotelchuck score of 76.5% in 2005 represents a very slight decline from 77.5% in 2003. Again, these differences are not large, but they are not moving in a favorable direction.//2008//

/2009/ Comparing the above Kotelchuck Index data for 2005 to 2006, the Medicaid Index of 70.7% has increased to 71.1, and the non-Medicaid Index of 76.5% has improved to 79.3. Again these favorable measures are encouraging. Still the increase for non-Medicaid births is more rapid than that for low income mothers, indicating a continuing widening of disparities. //2009//

/2010/ The Kotelchuck Index for Medicaid patients has improved with an increase to 73.3 in 2007. The non-Medicaid population has shown a comparable increase to 80.8. These measures show a slight improvement in adequacy of prenatal care, a difference from the slightly decreasing or flat trend in earlier data. //2010//

Health Systems Capacity Indicator 06A: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Infants (0 to 1)*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Infants (0 to 1)	2008	200
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Infants (0 to 1)	2008	200

Notes - 2010
Beginning July 2009 the income level to be eligible for Medicaid will increase to 250% of the federal poverty level.

Notes - 2010
Due to a new act adopted by the Arkansas legislature in 2009, the income eligibility for SCHIP may increase to 250% of the federal poverty level effective July 1, 2009. This may affect numbers of SCHIP enrollees in 2009.

Narrative:
Indicator 06 states the income level for financial eligibility for infants and pregnant women in the Arkansas State Medicaid Plan stands at 200% of poverty, a provision of the AR Kids First insurance program serving the large majority of low income pregnant women and infants. The same eligibility level exists in Medicaid for infants enrolled to be served with SCHIP funds. Eligibility increases to these levels have now existed for several years.

Using other information, insurance coverage data obtained from the ADH encounter management data (CY2006) reported 1.8% of women with a maternity code had private insurance coverage with 78.5% (8,721) under public insurance coverage, 14% (1605) were uninsured, and a remaining 5% (570) with unknown coverage. It is a practice of local health units to refer women with positive pregnancy tests to private doctors in the community if they have private insurance covering obstetrics. This conserves public clinic capacities for those not so fortunate, and enables a more collaborative relationship with private physicians. It is also notable that among a group of women, selected out by the system of care as very likely to be low income, only 14% were uninsured. This suggests that Medicaid expansions have had positive effects in reducing the "gap group" of pregnant women and their infants.

/2009/ Income eligibility policy in Medicaid has not changed. A recent discussion in the General Assembly questioning the legality of providing services to illegal aliens has not resulted in much programmatic change. A new planning effort is now being discussed with regard to increasing Medicaid eligibility for children to the 300% poverty level. So far resources have not been available that would make it feaaible to implement such a plan in the near future.//2009//

/2010/ During the 2009 Arkansas General Assembly, a measure was passed (Act 180) enabling the state to raise the income eligibility limit for Medicaid/ARKids First to 250% of the FPL. The expansion will be funded by an additional cigarette tax of 56 cents per pack, along with new taxes on smokeless tobacco products. ADH participated in a broad

coalition of organizations in favor of this tax, which will also finance a number of other health initiatives in Arkansas. The increased eligibility will apply to infants, children, and pregnant women.//2010//

Health Systems Capacity Indicator 06B: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Medicaid Children*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Medicaid Children	2008	
(Age range 1 to 4)		200
(Age range 5 to 9)		200
(Age range 10 to 18)		200
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Medicaid Children	2008	
(Age range 1 to 4)		200
(Age range 5 to 9)		200
(Age range 10 to 18)		200

Notes - 2010

Due to a new act adopted by the Arkansas legislature in 2009, the income eligibility for SCHIP may increase to 250% of the federal poverty level effective July 1, 2009. This may affect numbers of SCHIP enrollees in 2009.

Narrative:

This data indicates in more detail the State Medicaid Plan's provisions for low income pregnant women and children. The AR Kids A and B programs (A is made up mostly of Medicaid children and B is made up mostly of SCHIP children) have implemented these eligibility levels. Using 2003 data for AR Kids A and B enrollment, and US Census 2000 data to estimate the number of Arkansas children in families below 200% of poverty provided an estimate of 83% of all estimated eligible children were enrolled. That estimate was regarded as reasonably accurate, and a favorable rate of enrollment.

Current Population Survey data indicate that the estimated percentage of children in poverty in Arkansas has decreased over recent years as follows: 31.2% in 2002, 26.8% in 2003, 25.8% in 2004 and 24.9% in 2005. Parallel to this trend are declines in percentages of children who are uninsured as follows: 51.6% in the combined data years of 2001-2003 (a three-year moving average), to 49.6% in 2002-2004, to 47.6 in 2004-2005. Three year moving averages are used to "smooth out" the variability from year to year so the underlying trend is made visible.

Thus, two favorable trends are occurring simultaneously, there are fewer low income children, and fewer of them are uninsured. At this writing we do not have this data by race. Such information might help us to answer the question why this positive information should exist alongside increasing disparities for prenatal care, low birth weight, and infant mortality rates.

/2009/ Income eligibility for children still stands at 200% of poverty. There is some talk about raising it to 300% poverty, but resources have not been made available that would make such a change likely.//2009//

/2010/ During the 2009 Arkansas General Assembly, a measure was passed (Act 180) enabling the state to raise the income eligibility limit for Medicaid/ARKids First to 250% of

the FPL. The expansion will be funded by an additional cigarette tax of 56 cents per pack, along with new taxes on smokeless tobacco products. ADH participated in a broad coalition of organizations in favor of this tax, which will also finance a number of other health initiatives in Arkansas. The increased eligibility will apply to infants, children, and pregnant women.//2010//

Health Systems Capacity Indicator 06C: *The percent of poverty level for eligibility in the State's Medicaid and SCHIP programs. - Pregnant Women*

INDICATOR #06 **The percent of poverty level for eligibility in the State's Medicaid programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL Medicaid**
Pregnant Women	2008	200
INDICATOR #06 **The percent of poverty level for eligibility in the State's SCHIP programs for infants (0 to 1), children, Medicaid and pregnant women.**	**YEAR**	**PERCENT OF POVERTY LEVEL SCHIP**
Pregnant Women	2008	200

Notes - 2010

Due to a new act adopted by the Arkansas legislature in 2009, the income eligibility for SCHIP may increase to 250% of the federal poverty level effective July 1, 2009. This may affect numbers of SCHIP enrollees in 2009.

Narrative:

The information above states in more detail the provisions of the Arkansas State Medicaid Plan for financial eligibility for enrollment in Medicaid and SCHIP programs. In Arkansas, AR Kids A is made up mostly of Medicaid-enrolled children, and AR Kids B has a higher proportion of children enrolled in SCHIP. Medicaid for Pregnant women provides an eligibility level of up to 200% of poverty, while the "unborn child provision" program serving immigrant pregnant women also serves women to 200% of poverty.

Insurance coverage data obtained from the ADH encounter management data (CY2006) reported 1.8% of women with a maternity code had private insurance coverage with 78.5% (8,721) under public insurance coverage, 14% (1605) were uninsured, and a remaining 5% (570) with unknown coverage.

March of Dimes data reported during 2001-2003 (average), about 1 in 5 women of childbearing age in Arkansas were living in families with incomes below the Federal Poverty Level. One in 4 women of childbearing age were uninsured. The proportion of women in poverty and uninsured women are significantly higher than the national average level.

/2009/ Changes in poverty level eligibility in the Medicaid for Pregnant women program seems unlikely to occur this calendar year. However, the Arkansas General Assembly convenes again in January 2009, and the issue may arise then. //2009//

/2010/ During the 2009 Arkansas General Assembly, a measure was passed (Act 180) enabling the state to raise the income eligibility limit for Medicaid to 250% of the FPL. The expansion will be funded by an additional cigarette tax of 56 cents per pack, along with new taxes on smokeless tobacco products. ADH participated in a broad coalition of organizations in favor of this tax, which will also finance a number of other health initiatives in Arkansas. The increased eligibility will apply to infants, children, and pregnant women. //2010//

Health Systems Capacity Indicator 09A: *The ability of States to assure Maternal and Child Health (MCH) program access to policy and program relevant information.*

DATABASES OR SURVEYS	Does your MCH program have the ability to obtain data for program planning or policy purposes in a timely manner? (Select 1 - 3)	Does your MCH program have Direct access to the electronic database for analysis? (Select Y/N)
ANNUAL DATA LINKAGES Annual linkage of infant birth and infant death certificates	3	Yes
Annual linkage of birth certificates and Medicaid Eligibility or Paid Claims Files	3	Yes
Annual linkage of birth certificates and WIC eligibility files	3	Yes
Annual linkage of birth certificates and newborn screening files	3	Yes
REGISTRIES AND SURVEYS Hospital discharge survey for at least 90% of in-State discharges	3	Yes
Annual birth defects surveillance system	3	No
Survey of recent mothers at least every two years (like PRAMS)	3	Yes

Notes - 2010

Narrative:
The only "No" answer on this table relates to birth defects surveillance. While the ADH Center for Health Statistics, now called the Health Statistics Branch, does not have direct access to this data, there is a very sophisticated data sharing agreement between Health Statistics and the Birth Defects Surveillance and Research Program at Arkansas Children's Hospital. Linked birth/infant death data from ADH are matched to clinical birth defects data from Arkansas Children's Hospital, the identifiers are removed, and a research file is created for both agencies to use in their reporting. This collaboration has provided statistical information for a very strong birth defects surveillance program in Arkansas, recognized by CDC as one of the best in the nation.

/2009/ The Center for Birth Defects Surveillance and Research continues its exemplary progress. Recently, Dr. Charlotte Hobbs shared very new data that scientific evidence was beginning to show a correlation between maternal obesity and certain structural birth defects. The Center

continues to alert Arkansans to the fact that use of folate supplementation by women in the state continues to lag. //2009//

Arkansas is fortunate to have very high quality databases for births, infant deaths, fetal deaths, and hospital discharges. The same is true for programmatic databases for newborn hearing screening, newborn metabolic screening, cancer registries, STI data files, and many others. Also, PRAMS, BRFSS and Tobacco survey data programs are very strong in this state. While YRBS data for the statewide sample are gathered by the Department of Education in selected school districts. The Hometown Health Improvement Coalitions in many counties have stimulated their school districts to perform their own surveys. The Health Statistics Branch has provided the statistical and survey support to school districts wanting to do this, and has accumulated a good deal of local information on certain counties from time to time.

/2009/ The ADH Health Statistics Branch (HSB) (formerly the Center for Health Statistics) located in the Center for Health Practice, continues to work very effectively with the evaluation efforts of the Antenatal and Neonatal Guidelines for Education and Learning Systems (ANGELS) program. The Health Statistics Branch (HSB), receiving "pregnancy episodes" gleaned from Medicaid claims data by the evaluators, have been able to match up to 94% of those episodes to linked birth/infant death records, and additionally to hospital discharge records. The linkage has been achieved for a 24-month period prior to the start of ANGELS, and a 30 month period after the start of ANGELS. Detailed analysis of these data are now being conducted and publications planned. An initial methodology paper will be published soon in the MCH Journal. //2009//

/2009/ The HSB, with considerable contributions from the ADH MCH Epidemiologist, provided the necessary data and consultation on trend interpretations for the Infant Mortality presentation given by Dr. Nugent to ADH Grand Rounds last spring. //2009//

/2010/ Although the situation regarding reporting on birth defects is unchanged, access to information through the YRBS, BRFSS, PRAMS, the multiple databases for births, infant deaths, fetal deaths, hospital discharges, newborn hearing screening, newborn metabolic screening, cancer registries, STI data files, and many others remains very good. New efforts to share this information through partnerships between ADH and other organizations are taking place. It is hoped that the proliferation of these partnerships and the sharing of information will result in a synergy that will have a greater impact on the state's health. //2010//

Health Systems Capacity Indicator 09B: *The Percent of Adolescents in Grades 9 through 12 who Reported Using Tobacco Product in the Past Month.*

DATA SOURCES	Does your state participate in the YRBS survey? (Select 1 - 3)	Does your MCH program have direct access to the state YRBS database for analysis? (Select Y/N)
Youth Risk Behavior Survey (YRBS)	3	No
Youth Tobacco Survey	3	Yes

Notes - 2010

Narrative:
See comments from the previous Health Systems Capacity Indicator regarding other statistical capabilities, wherein the ADH Center for Health Statistics (now the Health Statistics Branch of the Center for Health Practice) has access to statistics obtained by individual school districts that they support.

/2010/ Access to this information continues to be very good. //2010//

IV. Priorities, Performance and Program Activities

A. Background and Overview

1. Introduction

The MCH Block Grant Planning Team, in the light of the recommendations from the Stakeholders' group and the trends seen in the Performance Measures, decided to continue with all state priorities followed in the past, and to add one more State Performance Measure. The tenth priority is devoted to measuring BMI in Family Planning patients, provide education and written materials to clients, and make referrals to community sources of support for healthy lifestyles with respect to nutrition and physical exercise. Within state priorities devoted to Pregnant Women and Infants, Children, and Children with Special Health Care Needs, new activities will be added to implement the four new partnerships recommended by the Stakeholders.

2. The MCH Planning Team selected the following priorities:

a. To reduce the percentage of women smoking during pregnancy
b. To reduce the percentage of high school students engaging in sexual intercourse
c. To increase the percentage of children 0-18 and below 200% of poverty who are enrolled in the AR Kids First Program
d. To increase the percentage of pregnant women counseled for HIV testing
e. To reduce the percentage of children who are overweight among WIC children 0-5 years of age.
f. To increase the percentage of 14 and 15 year olds on CMS who state that CMS transition services have helped improve their knowledge/ability to transition to adult life
g. To increase the percentage of parents responding on the CMS Parent Satisfaction Survey that CMS service coordination teams told them about other services available to them
h. To reduce the percentage of public school students who are overweight (greater than the 95th percentile of weight for height)
i. To reduce the percentage of public school students at risk for overweight (85th to 95th percentile of weight for height)
j. New: To increase the percentage of Family Planning clients with BMI greater than the 85th percentile who receive educational materials in the Family Planning clinics, and are referred to community sources of counseling and support.

The primary change in the priorities listing was to add a new priority as listed in j. above.

The process to determine the priority needs began with a thorough review of data elements relative to a wide range of health issues relevant to women and children. Organizers of the Needs Assessment effort established the MCH Planning Team, made up of leaders from Family Health including the Perinatal Health and Reproductive Health Programs in Women's Health Work Unit, the Child and Adolescent Health Work Unit, the Oral Health Work Unit, the WIC Work Unit and the Children's Medical Services Program of the Department of Human Services. The Planning Team then organized a group of external Stakeholders to obtain input from a wide range of community, university, academic and state agency leaders to share their priorities.

The partnership building effort began with the formation of the Stakeholders' group. The Stakeholders developed a list of 14 priority issues of importance to women and children presented in the following list:

a. Obesity, nutrition and physical activity
b. Access to care, especially for prenatal care, routine child care, and CYSHCN
c. Smoking and tobacco use

d. Chronic diseases, especially obesity, diabetes, hypertension, cancer and heart disease
e. Needs for health education and behavior change, especially public awareness and marketing, sexuality and early prenatal care
f. Communicable diseases, especially HIV, STDs, Immunization-preventable illness
g. Need to address health system complexity through care coordination and family-centered approaches such as the medical home
h. Need to improve child health screening programs and care coordination, Especially EPSDT, Newborn screening and AR Kids First as a way to support preventive
services
i. Mental health, suicide, depression and chronic stress
j. Application of distance communications technology -- telemedicine, distance learning, knowledge management, consultation and referrals
k. Oral health for all children, but especially for pregnant women and CYSHCN
l. Domestic violence prevention
m.Injury prevention
n. Substance abuse treatment and prevention including alcohol.

As the Planning Team reviewed the national priorities and chose the state priorities, the above list was considered.

a. Pregnant women and infants
b. Children's services and systems of care
c. Children and youth with special health care needs, and
d. Women

Four planning partnerships are envisioned in Priority j. in Section 2.

The MCH Planning Team considered these priorities and recommendations in completing the needs assessment. They recognized that many of the themes of interest presented in the Stakeholders' priority list were already being addressed through priorities that existed in the national performance measures, especially the access to care issues for pregnant women, children and children with special health care needs.

/2007/ Priorities have not changed, however the configuration of planned partnerships has changed, as they have developed. While the Pregnancy and Infant Partnership has remained the same (ANGELS - Medicaid, UAMS and ADH), the child health partnerships activities are new. For Primary and Preventive Health Services for Children, the Division of Health is working closely with the Division of Child Care and Early Childhood Education, as well as the Division of Developmental Disabilities Services (the Children's Medical Services [CSHCN] Program is in this Division and is also involved) in the Arkansas Early Childhood Comprehensive Systems partnership. Significant strides have been made toward the development of a "tiered quality of service" system for Arkansas.
Recommendations for five "tiers" have been developed and accepted. The DDS of DHS and ADH are also working together on a statewide initiative for Child Mental Health Services. The ADH partnership with Community Health Centers is taking the form of increased referral of Family Planning patients with chronic diseases,
and now obesity to CHCs for followup care. //2007//

/2008/ Priorities have not changed. Major strides are being made in partnerships with UAMS OB/GYN (ANGELS), DHS Division of Mental Health (System of Care), DHS Division of Child Care and Early Childhood Education (Early Childhood Education Quality Rating System, and with The Department of Education (Coordinated School Health). BMI measurement and provision of counseling for nutrition and weight control are advancing. The method of measuring the success of efforts to educate family planning patients about obesity and high BMI has changed to accommodate available data.//2008//

/2009/ Partnerships have rapidly developed. System of Care for Children's Mental Health - During the 2008 session the AR General Assembly, influenced by a many-page list of agencies in the SOC partnership, passed legislation providing the principles for the planning and development of a statewide infrastructure to build a system of care for children's mental health. Funding was also made available to provide incentives for the development of community services for children's mental health. The Children's Behavioral Health Commission, established by the legislation, met in June, 2008. The Department of Human Services and its Division of Behavioral Health presented an implementation plan to the Commission which voted to recommend the plan for approval by DHS. That plan provided for a Request for Proposal Process to fund at least two community projects to initiate system development at the local level. Meanwhile, collaborative efforts of all related divisions and departments have gained momentum. The Commission felt that much more progress should be made to develop collaborative efforts with the Department of Education. State agencies agreed to form workgroup for that purpose. //2009//

/2009/ Other Partnerships are discussed in Part B of this State Narrative. //2009//

/2010/ The Arkansas MCH BG continues to operate with the same priorities and performance measures established at the beginning of this five-year cycle. However, intense efforts at strategic planning, and needs assessments continue and grow. This year a process of "networking the networks" continues to unfold in which new consensus around program priorities emerges. The process of focusing on certain priorities with the intention of clarifying and implementing specific interventions goes on.//2010//

B. State Priorities

At the beginning of this five-year cycle, the MCH Planning Team selected the following State Priorities:

· To reduce the percentage of women smoking during pregnancy

Working with the ANGELS project, new screening tools for smoking assessment are being developed that will be incorporated into maternity clinic services in the state.

· To reduce the percentage of high school students engaging in sexual intercourse.

Abstinence Education and Unwed Birth Prevention programs continue to fund special project grants in selected communities to reduce adolescent sexual activities. The selection process for these grant programs favors larger cities with the intent of impacting on the state rates as much as possible.

· To increase the percentage of children 0-18 and below 200% of poverty who are enrolled in the AR Kids First Program

The State Medicaid Program continues to prioritize enrolling eligible children in the AR Kids A and B programs, and Local Health Units, when they identify children from low-income families in WIC and Immunization clinics continue to make referrals to local Human Services County Offices.

· To increase the percentage of pregnant women counseled for HIV testing.

Local Health Unit prenatal clinics continue to counsel prenatal patients about the need for HIV testing, and offer the test.

· To reduce the percentage of children who are overweight among WIC children 0-5 years of age.

The Healthy Arkansas Initiative, supported by the Governor and state health and education agencies is prioritizing the identification of overweight and at risk for overweight children in schools an other places, and developing community support for counseling and other follow-up. The WIC Program continues to measure heights and weights, to calculate percentiles of height for weight, to give nutritional advice to children at risk, and to refer to community sources of support.

· To increase the percentage of 14 and 15 year olds on CMS who state that CMS transition services have helped improve their knowledge/ability to transition to adult life

The CSHCN Program continues to emphasize its educational and case management services for 14 and 15 year old services with the emphasis on educating about transitional issues and services.

· To increase the percentage of parents responding on the CMS Parent Satisfaction Survey that CMS service coordination teams told them about other services available to them

· To reduce the percentage of public school students who are overweight (greater than the 95th percentile of weight for height)

At the beginning of school this fall, all schools will be again measuring heights and weights, and informing parents of children who are at risk for overweight or overweight. Major activities in schools to improve the nutritional value of foods available through food services are under way. The Child HealthAdvisory Committee, established through Act 1220 has made major recommendations to the Governor and to the Board of Education and Health regarding new rules to be adopted by the Board of Education. Work on these new rules should culminate in the next few months.

· To reduce the percentage of public school students at risk for overweight (85th to 95th percentile of weight for height) (see above)

· New: To increase the percentage of Family Planning clients with BMI greater than the 85th percentile who receive educational materials in the Family Planning clinics, and are referred to community sources of counseling and support.

The primary change in the priorities listing was to add a new priority as listed in j. of Section 2.

The MCH Planning Team, in completing the requirements for national performance measures and state performance measures are thereby responding to the Stakeholders' interests as follows

· Obesity, nutrition and physical activity

This Stakeholder priority is addressed in National Performance Measure 10 (Breastfeeding), State Performance Measures 27 (WIC children over 95th percentile weight for height), 30 (students over 95th percentile) and 31 (students at risk for overweight).

· Access to care, especially for prenatal care, routine child care, and CYSHCN

This Stakeholder priority is addressed for pregnancy in National Performance Indicator 18 (Births with first trimester care); and for child care and CYSHCN in National Performance Measures 2-6 (CSHCN measures of availability of coordinated care), 13 (children without health insurance), and 14 (potentially eligible children receiving a service), and State Performance Measures 22 (Children <200% poverty enrolled in AR Kids A and B), and 29 (CSHCN children receiving coordinated services).

· Smoking and tobacco use

This Stakeholder priority is addressed in State Performance Measure 32 (women smoking in pregnancy).

· Chronic diseases, especially obesity, diabetes, hypertension, cancer and heart disease

This Stakeholder priority is addressed in a new State Performance Measure 33 (measuring body mass index in Family Planning clinics and providing patient education and referral)

· Needs for health education and behavior change, especially public awareness and marketing, sexuality and early prenatal care

This Stakeholder priority is addressed in National Performance Measures 8 (birth rate for adolescents) and 18 (first trimester prenatal care), and State Performance Measures 21 (students having sexual intercourse) 24 (HIV counseling and testing), 30 (overweight children in schools), and 31 (students at risk for overweight).

· Communicable diseases, especially HIV, STDs, Immunization-preventable illness

This Stakeholder priority is addressed in National Performance Measure 7 (immunization by age 2), and State Performance Measure 24 (pregnant women counseled and tested for HIV).

· Need to address health system complexity through care coordination and family-centered approaches such as the medical home

This Stakeholder priority is addressed in National Performance Measures 2-6 (CSHCN access to care measures), and State Performance Measures 28 (14 and 25 year olds receiving transitional education and referral), and 29 (parents receiving service coordination).

· Need to improve child health screening programs and care coordination, Especially EPSDT, Newborn screening and AR Kids First as a way to support preventive services

This Stakeholder priority is addressed in National Performance Measures 1 (newborn screening), 2-6 (CSHCN measures), 7 (immunizations), 9 (third graders with sealants), 10 (breastfeeding), 12 (newborn hearing screening), and 14 (potentially eligible children receiving services in Medicaid).

· Mental health, suicide, depression and chronic stress

This Stakeholder priority is addressed at the level of creating two new planning partnerships, one around children's services and systems of care, and one around children with special health care needs. The development of these two partnerships is addressed in several state performance measures.

· Application of distance communications technology -- telemedicine, distance learning, knowledge management, consultation and referrals

This Stakeholders priority is addressed in the formation of a partnership around pregnancy and infant health care and plans for its implementation appear in the State Performance Priority for smoking in pregnancy.

· Oral health for all children, but especially for pregnant women and CYSHCN

This Stakeholder priority is addressed in National Performance Measure 9 (Third graders and sealants)

· Domestic violence prevention

This Stakeholder priority will be addressed through the pregnancy and infant health partnership, and is being developed through the existing partnership with UAMS OBGYN department project ANGELS.

· Injury prevention

This Stakeholder priority is addressed in National Performance Measure 10 (motor vehicle death rate for children).

· Substance abuse treatment and prevention including alcohol.

This Stakeholder priority will be addressed through the development of the partnership for children, and the partnership for women.

/2007/ Priorities for MCH planning have not changed. However, the partnerships in which Title V staff are participating have developed considerably. The ANGELS partnership continues and is growing. The Child Health Partnership is working through three programmatic groups - Coordinated School Health Initiative, the Child Mental Health Initiative, and the Arkansas Early Childhood Health Comprehensive Systems planning and implementation efforts. The women's health partnership is forming around obesity identification in Family Planning Clinics, provision of educational information to those at risk, and working in communities to develop resources to aid these clients in better weight management. The Healthy Arkansas campaign is a community based effort to increase physical activity, eat healthy, and smoke less. //2007//

/2009/ While priorities have not changed for purposes of this grant, Arkansas has made strides in the development of Partnerships. The System of Care Partnership was discussed in the Background and Overview section of this narrative.//2009//

/2009/ -Arkansas Early Childhood Comprehensive Systems (AECCS): Funded by the national ECCS program of MCH Bureau, and led by Martha Reeder of the Division of Child Care and Early Childhood Education (DCCECE), Arkansas began its collaborative efforts by developing a recommendation for a "tiered quality of service" Quality Rating System (QRS) system for Arkansas Early Childhood Education (ECE) providers. ADH, UAMS, and others worked closely on the health aspects of those guidelines. The recommendations were developed with the input of the state's association of early childhood education providers and adopted by the DCCECE which found funds to incentivize ECE providers to advance their services according to the guidelines. The first two tiers were targeted in the first year of implementation. The Early Childhood Commission closely followed the progress of the AECCS effort. Many details of this process are presented in project reports to the MCHB.

/2010/ Now called the Quality Rating Improvement System (QRIS), that process is now addressing the third tier of quality recommendations. DCCECE, working with early childhood education providers, is refining the original recommendations by operationalizing them as appropriate for those settings, bringing clarity for implementation. //2010//

/2009/ -Assuring Better Child Development (ABCD): Growing out of the AECCS Partnership, and coordinated by Martha Hiett of DCCECE, Arkansas applied and was included in a national technical assistance effort called ABCD. Ms. Hiett set up a Core Team, including Ms. JoAnn Bolick of the ADH Child and Adolescent Health
Section of Family Health, and a Stakeholder's Committee including Dr. Richard Nugent. Arkansas Medicaid and the Arkansas Foundation for Medical Care (AFMC - the PRO organization) participated in critical aspects of this plan. A productive part of this effort, the

Medical Subcommittee, convened to review national offerings for validated tools to screen for developmental disabilities. They recommended several tools, but preferred the Ages and Stages Questionnaire. The Committee purchased copies of the questionnaire and shared them with two private practices willing to pilot their use. Dr. Dennis Yelvington, a family physician in Stuttgart, and Dr. Chad Rogers, a pediatrician in Little Rock agreed to integrate the use of this tool into the staff duties in their offices. A significant aspect of this instrument is obtaining information directly from parents at the start of the ssessment. Both practices have reported to the ABCD Stakeholders' Committee of success with applying the tool, and are now in the process of informing their statewide physician colleagues. Medicaid established special reimbursement codes so that these additional services received compensation. In addition, Medicaid, through a contract with AFMC, has provided technical assistance through direct and frequent visits to these pilot practices. AFMC and Medicaid have also developed relationships with as many as 50 other practices to become pilots to enhance EPSDT screening and preventive services. AECCS has now adopted a "statewide spread strategy" to extend the use of the ASQ or other instruments to those practices. Staff of AFMC are able to visit these practices at least annually and more frequently where practice interest exists. //2009//

/2009/ -The National Center for Children in Poverty policy initiative (NCCP): Arkansas pursued a technical assistance process with the NCCP to develop policy for early childhood services. Also coordinated by Ms. Hiett of DCCECE, this policy process incorporated all the partners of the System of Care for Child Mental Health (See Background and Overview), AECCS, and ABCD; Arkansas Advocates for Children and Families; representative of family practice and pediatrics; the State Primary Care Agency; and many other public and private entities interested in serving children. Guided by Ms. Kay Johnson, a nationally recognized technical assistant for policy development for children, the process resulted in a set of recommendations for both policy development and program enhancement. The group made a clear recommendation to Medicaid that it should require its primary care providers to perform developmental assessments by a validated tool. At that meeting the ADH expressed interest in enhancing services around the state for care coordination in the area of child health.//2009//

/2009/ -Project LAUNCH (Linkages to Address Unmet Needs in Child Health): In May, ADH became aware of the opportunity to apply for a grant jointly sponsored by MCH Bureau and the Substance Abuse and Mental Health Services Agency (SAMHSA) called Project LAUNCH. Through a combined effort of the DHS Divisions of DCCECE and Behavioral Health, also involving Partners for Inclusive Communities of UAMS, and the ADH Child and Adolescent Health Section of Family Health, Arkansas submitted a proposal establishing a statewide Early Childhood Partnership Council made up of many of the partners participating in the above efforts. For its community-based effort, Dr. Dennis Yelvington of Stuttgart again stepped up, agreeing to add to his use of the Ages and Stages Questionnaire its component assessment for Socio-Emotional Development. Arkansas is likely to proceed with the formation of the Partnership Council, even if the application does not succeed.//2009//

/2009/-Newborn Screening (NBS) expansion. As of July 1st, Arkansas expanded its newborn screening program to include screening for all 29 nationally recommended conditions. Movement toward this expansion began with a White Paper from ADH, involving collaborators from the office of the Deputy Director, the Science Advisory Committee, the office of General Council, the State Laboratory, and the Family Health Branch, chiefly the Child and Adolescent Health Section. The White Paper recommendation to expand was adopted by the Board of Health initiating regulation which set the new fee at $89.25 per specimen submitted, and provided for the participation of hospitals and insurance companies throughout the state. Arkansas had already been screening for 6 metabolic conditions and also newborn hearing screening, with major staff efforts to notify primary care physicians and families of abnormal results on initial screenings. Nevertheless, the addition of the 22 conditions, especially Cystic Fibrosis and Congenital Adrenal Hyperplasia required extensive and detailed collaboration between the ADH Lab and the CAH follow-up program, as well as critical technical assistance from the UAMS Department of Pediatrics' subspecialists (hematology, biochemical genetics, endocrinology, and pulmonary medicine) to

produce protocols guiding the agencies and primary care physicians to respond appropriately to each of the conditions identified on initial screening. Follow-up not only by the ADH Child and Adolescent Health Section, but pediatric subspecialists, and particularly the specialty clinics at Arkansas Children's Hospital (ACH) was also included in the protocols being developed. Finally, ADH and the Arkansas Children's Hospital Laboratory made plans to deal appropriately with "first and second tier" studies for Cystic Fibrosis and Congenital Adrenal Hyperplasia. Preparations for the expansion included public and professional awareness campaigns conducted in June 2008 with the assistance of the ADH Public Information Office and similar offices of UAMS, ACH, St. Vincent's Hospital and the Baptist Health System.//2009//

/2010/ Although the first LAUNCH application was not successful, a lengthy critique from SAMHSA was very helpful in improving it. ADH and the DCCECE applied again this year. Planning with the local community - Stuttgart and Arkansas County - has proceeded into more detail, identifying a lead agency there.//2010//

/2010/ As of this writing (June, 2009), the NBS expansion is unfolding with remarkable smoothness. New conditions screened for, especially MCAD and Cystic Fibrosis, are being identified in the birth population with frequencies that can be expected. The detailed protocols for screening for all conditions have been written and incorporated in the computer system and database. Regular meetings between the ADH Lab, the Child and Adolescent Health Section follow-up staff, and the Children's Hospital subspecialists and Genetics Lab have occurred, helping to smooth daily communications. //2010//

C. National Performance Measures

Performance Measure 01: *The percent of screen positive newborns who received timely follow up to definitive diagnosis and clinical management for condition(s) mandated by their State-sponsored newborn screening programs.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	98	98	100	100	100
Annual Indicator	97.6	100.0	100.0	100.0	100.0
Numerator	41	44	46	33	47
Denominator	42	44	46	33	47
Data Source					Newborn Screening Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	100	100	100	100	100

Notes - 2006
Information obtained from Newborn Screening Program.

a. Last Year's Accomplishments
1. The implementation of the expanded Newborn Screening (NBS) Program began July 1, 2008.

2. A web page for the Newborn Screening Program was established on the Arkansas Department of Health (ADH) website.

3. Through a financial agreement, the University of Arkansas for Medical Sciences (UAMS) Department of Pediatrics collaborated with the Department of Health to develop follow-up NBS protocols for the 28 conditions in the expanded NBS panel. In addition, a contract with UAMS Department of Pediatrics/Arkansas Children's Hospital sub-specialty clinics (pulmonary, genetics, endocrinology, hematology) was established to provide physician consultation, coordination of referrals, and tracking and monitoring of follow-up services for the ADH NBS Program. As a result, a Newborn Screening Coordinator position was established at UAMS/ACH, beginning July 1, 2008. This position serves as a channel of communication between the two entities and assists with tracking and monitoring of newborns referred to ACH for follow-up.

4. Site visits to all 47 birthing hospitals across the state were made by a follow-up nurse in the NBS Program to provide training to the nursery and ICU staff on the expanded program and blood collection procedures. A DVD on blood collection was provided along with the ADH co-branded March of Dimes parent brochures on NBS in English and Spanish.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Heelstick specimens from newborns were collected by all birthing hospitals in the state, as mandated by law. "Blood spots" were put on absorbent cards.			X	
2. The blood spot specimen cards were sent to the State Health Laboratory for testing.			X	
3. All abnormal results were sent to the NBS Follow-up Program in the Child & Adolescent Health Section where the nurses reviewed the results and provided follow-up according to the NBS Medical Director and the NBS Protocols.			X	
4. Abnormal results were reported by phone, fax, and mail according to NBS Protocols to the physician of record on the specimen card. Also, hemoglobinopathy traits were reported by mail to the parent as well as the physician of record.			X	
5. The NBS Program was expanded July 1, 2008 to screen for the 29 Primary Core Conditions.			X	
6. The PerkinElmer Lab database was implemented July 1, 2008; the Patient Care (Follow-up Program) database was piloted and validated between September 2008 through February 2009.				X
7. The ADH NBS Program co-branded the March of Dimes Parent Brochures on NBS and distributed these in English and Spanish to all the birthing hospitals in the state.		X		
8. The NBS Nurse Educator visited all the birthing hospitals in the state between July and August 2008 providing inservice				X

training on the NBS expansion.				
9. The ADH NBS Program established a NBS web page on the ADH web site with the expanded program, on July 1, 2008 to provide information for professionals and parents.				X
10. The NBS Program established a toll-free number with the expanded program, beginning July 1, 2008. This number was placed on all correspondence to physicians, hospitals, and parents.				X

b. Current Activities

1. Revisions were made to the Follow-up NBS Protocols to fit the Arkansas population. Cut-off values for conditions such as CAH were adjusted. The protocols for all disorders were reviewed for best practices and updated accordingly.

2. Site visits continue to the birthing hospitals across the state by the NBS Nurse Educator to offer technical assistance with the objectives to decrease rejection rates and improve timeliness of submission.

3. The Arkansas Genetic Health Committee continues to meet quarterly, and the Bylaws have been revised to form three sub-committees: Newborn Screening and Laboratory Services, Pediatric Genetic Services, and Adult Genetic Services.

4. The NBS Program nurses continue to work closely with the NBS Coordinator at UAMS/ACH, to coordinate follow-up care for babies with abnormal newborn screening results. Meetings are being held bi-monthly to review and coordinate follow-up activities.

5. The Patient Care Module (Follow-up Program)of the PerkinElmer database began the pilot phase of implementation 9-08. The validation phase began in 10-08 and continued through 2-09. On 03-01-09, the NBS staff began to use the database fully. The NBS staff continue to maintain a hard copy patient file, and at the same time are moving towards an electronic filing system.

6. With the expanded NBS, 3 CF, 1 CAH, and 1 MCAD cases were identified between 07-1-08 and 12-31-08 in addition to the reported cases for 2008 on Form 6.

c. Plan for the Coming Year

1. The Nurse Educator will tailor training and technical assistance to individual hospitals needs during site visits to birthing hospitals. In particular, the rejection rates for newborn screening specimens will be reviewed and the nursery and/or hospital laboratory staff will receive training.

2. The Bylaws of the Arkansas Genetic Health Committee have recently been revised to incorporate the three new sub-committees. This will increase Committee membership and expand the scope of the Committee, leading to the development of an Arkansas State Genetic Plan.

3. The Follow-up NBS Protocols will be reviewed annually and as needed and will be updated accordingly.

4. The Arkansas Newborn Screening web page will be enhanced to add more information and resources for parents and professionals and to provide contact names and information on NBS Program staff.

Performance Measure 02: *The percent of children with special health care needs age 0 to 18 years whose families partner in decision making at all levels and are satisfied with the services they receive. (CSHCN survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	77	55	56	57	62
Annual Indicator	53.7	53.7	53.7	61.7	61.7
Numerator	12952	12952	12952	468	468
Denominator	24116	24116	24116	759	759
Data Source					Data from Nat'l CSHCN Survey, 2005-2006
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	63	64	65	66	67

Notes - 2008
Indicator data is from the National Survey of CSHCN conducted in 2005 - 2006.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM02 indicator for both the 2001 and the 2005-2006 CSHCN survey. Data from our statewide survey completed in April 2008 was slightly higher at 65%.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.
This information was not addressed on the 2006 CSHCN Transition Survey.

a. Last Year's Accomplishments
The Title V Family Support/Respite Program was managed between the caseworkers and the Regional Managers. Decision making was pushed down in the chain of command to give caseworkers the ability to determine eligibility. Each Region of the state was given funding to utilize for a variety of purposes based on the child and family's needs. Caseworkers could also make referrals and provide assistance via the DDS programs Special Needs and Integrated Supports. 284 awards were made via the Title V Family Support/Respite Program and DDS Special Needs during the year. DDS Integrated Supports served 11 individuals in crisis situations enabling them to live in their community independently. A survey was mailed to a random sampling of families on the CSHCN database. Caseworkers addressed individual needs mentioned on the returned surveys. Referrals are routinely made to the Child and Adolescent Service System Program (CASSP) which involves a multi-agency team including the family. Services are recommended and funded to assist the family and the child/adolescent in a manner that enables the youth to remain in their home and community.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. CSHCN caseworkers made referrals to the 15 child & Adolescent Service System Program (CASSP) Coordinators & participated on local & regional teams that work with youth with mental health & behavioral health issues.				X
2. CSHCN caseworkers worked with children & youth with developmental disabilities & their families via the Special Needs program to fund services not available elsewhere.		X		
3. CSHCN caseworkers provided referral to the Integrated Supports program for children & youth with developmental disabilities in intense crisis situations.		X		
4. Title V Family Support/Respite Program was available to help meet a child or family's needs. Need established by level of care, income & disability determination.		X		
5. CSHCN Parent Advisory Council met quarterly with members coming from around the state. Members of the council made recommendations for the program & shared information with local parent support groups.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Title V Family Support/Respite Program has continued utilizing the same format with home visits required. The DDS Special Needs and Integrated Supports programs continue utilizing DDS state general revenue.

c. Plan for the Coming Year

The CMS Parent Advisory Council has pledged to assist with regional public forums for the upcoming Needs Assessment.

Performance Measure 03: *The percent of children with special health care needs age 0 to 18 who receive coordinated, ongoing, comprehensive care within a medical home. (CSHCN Survey)*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	54	55	56	68	68
Annual Indicator	52.2	52.2	65.9	50.2	50.2
Numerator			120	379	379
Denominator			182	755	755
Data Source					This data comes from the National Survey of CSHCN
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and					

2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	54	57	58	59	60

Notes - 2008
This data comes from the National Survey of CSHCN 2005 - 2006.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions and additions to the questions used to generate the NPM03 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #03. Our statewide survey response to the question "After reading about Medical Home, do you believe your child's primary care doctor meets the qualifications of a Medical Home?" had a "Yes" response of 84%.

Notes - 2006
Data source: 2006 CSHCN Transition Survey

a. Last Year's Accomplishments
The Parent Coordinator for the CSHCN program and some of the Parent Advisory Council members participated in Project DOCC training for UAMS Residents during their Pediatrics rotation. The Parent Coordinator served on the Parents as Educators Advisory Committee at AR Children's Hospital. Program staff continues to utilize the Medical Home display and brochures at community meetings around the state. A survey was mailed to 714 families and included information on the Medical Home with questions that rated how their primary care provider measured up to that standard. Respondents generally rated their primary care providers highly as a Medical Home even when they responded in the negative on some of the recognized characteristics of a Medical Home.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Information on Medical Home was provided to families in a publication “You Are Not Alone” which was developed in conjunction with the Developmental Disabilities Council.		X		
2. Medical Home display and handouts were available for CSHCN caseworkers to use at consumer and professional meetings statewide.		X		
3. Program Administrator participated in Departmental workgroups on Medical Home targeting Early Childhood programs and Foster Children.				X
4.				
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
Project DOCC ended 5/31/09 due to lack of funding for stipends for participants. The past year's funding was made available through a grant from the Developmental Disabilities Council. The Program Administrator is working with a DHS group focusing on Medical Home issues for Medicaid recipients. Initial work is being done focusing on the special needs and issues of Foster Children. The Program Administrator also works on a Medical Home workgroup serving as a subcommittee for the Arkansas Early Childhood Comprehensive Systems initiative. An initial task has been to research literature for a definition of Medical Home for the "lay" community that remains true to the definition developed and supported by the AAP and AAFP.

c. Plan for the Coming Year
Continue work with departmental Medical Home workgroups to obtain permissions to utilize work products from other states or develop material for use within the state. Utilize materials to continue staff and family education related to the Medical Home concept.

Performance Measure 04: *The percent of children with special health care needs age 0 to 18 whose families have adequate private and/or public insurance to pay for the services they need. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	67	56	57	62	66
Annual Indicator	54.5	54.5	61.5	66.5	66.5
Numerator	103	103	112	493	493
Denominator	189	189	182	741	741
Data Source					Data comes from the National Survey of CSHCN 2005
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	67	68	69	70	70

Notes - 2008
Data comes from the National Survey of CSHCN 2005 - 2006.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. The same questions were used to generate the NPM04 indicator for both the 2001 and the 2005-2006 CSHCN survey. Our statewide survey completed in April 2008 indicates that 65% of respondents state that insurance (public or private) covers the cost of their child's care. Yet on a question about out of pocket medical costs with 92 affirmative respondents, 47% paid from $1 to $1000 per year and 28% paid over $1000 per year out of pocket.

Notes - 2006

Data source: 2006 CSHCN Transition Survey

a. Last Year's Accomplishments
The Title V Family Support/Respite Program completed the first year by providing funds for 255 families. Applications were taken and evaluated at the local and regional level as caseworkers worked with families and became aware of the unmet needs of the child and family. In addition to these funds, the DDS Special Needs program provided funding to 56 families to assist with unmet needs for developmentally disabled family members.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Provided payment for specialized care for approximately 263 CSHCN in combination with private health insurance at AR Children's Hospital & other local hospitals & medical providers around the state.	X			
2. Provided payment for diagnostic workups on approximately 328 children who were suspected of having an eligible condition in combination with private insurance providers.	X			
3. Evaluated all applicants for possibility of eligibility for other financial & disability categories of Medicaid.		X		
4. Provided payment for services for 144 Medicaid recipients that were not covered under the Medicaid state plan (purchase of medical equipment, van lifts, ramps, compound drugs, medical food for PKU, etc.).	X			
5. Provided payment for Family Support/Respite/Medical Camp 226 CSHCN with Medicaid coverage.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Program Administrator investigated the possibility of returning to a contract with the state's Pediatric specialty hospital and found that there would be no appreciable difference between monitoring a contract under current procedures and continuing a fee-for-service payment arrangement. No changes will be made at this time.

c. Plan for the Coming Year
The upcoming Needs Assessment and subsequent Strategic Planning process will provide a work plan for the program to determine what changes may need to be made to better serve CSHCN and their families. If dramatic changes are required, the CSHCN State Plan must be revised to reflect the changes.

Performance Measure 05: *Percent of children with special health care needs age 0 to 18 whose families report the community-based service systems are organized so they can use them easily. (CSHCN Survey)*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008

Annual Performance Objective	72	50	51	52	90
Annual Indicator	48.9	48.9	48.9	89.1	89.1
Numerator	64	64	64	688	688
Denominator	131	131	131	772	772
Data Source					Data comes from the National Survey of CSHCN 2005
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	90	90	90	90	90

Notes - 2008
Data comes from the National Survey of CSHCN 2005 - 2006.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were revisions to the wording, ordering and the number of the questions used to generate the NPM05 indicator for the 2005-2006 CSHCN survey. The data for the two surveys are not comparable for PM #05.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.
This information was not addressed on the 2006 CSHCN Transition Survey

a. Last Year's Accomplishments
CSHCN staff worked on community coalitions such as: Interagency Coordinating Councils, Hometown Health Initiative councils, Child & Adolescent Service System Program (CASSP) teams (local, regional and state), and local DHS Management Teams. Staff participated in focus groups for the Natural Wonders project (funded by a coalition including AR Advocates for Children & Families, AR Blue Cross Blue Shield, AR Center for Health Information, AR Chapter-American Academy of Pediatrics, AR Children's Hospital, AR DHS, UAMS College of Public Health, UAMS College of Medicine, AR Kids Count Coalition & the University of AR Clinton School of Public Service). Attendees discussed issues of concern in their region. All results were compiled and cross-cutting issues were brought forward for discussion and development of a plan to address the issues. CSHCN staff worked with the ABCD Stakeholders group which developed a strategy for increasing EPSDT screens in the state and providing guidance to physicians on the use of developmental screening tools including Autism screening tools at specific time periods during a child's life.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. CSHCN staff served as care coordinators for children/youth & their families who have requested such assistance by completing a Needs Assessment and Plan of Care with the family.		X		

2. CSHCN staff were primary contacts for several programs within DDS, and assisted in completion of and gathering documentation that provided access to those programs and services.		X		
3. CSHCN staff represented the disability community on local councils and committees involved in development of local infrastructure.				X
4. CSHCN staff participated in public awareness activities by making visits to local medical providers, DHS offices and other local programs within the community to provide information on programs available.				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities

CSHCN staff continue to serve on local, regional and state coalitions representing the special needs and developmental disabilities community. These include Hometown Health Initiative, CASSP (local, regional and state), the DHS Policy Workgroup, AR Early Childhood Comprehensive Systems workgroup, the Oral Health Coalition, the Finish Line Coalition (statewide group whose focus is advocacy and outreach for health care coverage for all children), the Governor's Roundtable on Health Care and the AR Genetic Health Committee. The proposed financial incentives to improve the EPSDT rates were put on hold due to the current economic status, but Medicaid continues to support the plan.

c. Plan for the Coming Year

CSHCN staff will continue to work on public awareness activities related to the programs that are available for CSHCN and their families.

Performance Measure 06: *The percentage of youth with special health care needs who received the services necessary to make transitions to all aspects of adult life, including adult health care, work, and independence.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	7	11	11	15	34
Annual Indicator	10.5	10.5	10.5	33.1	33.1
Numerator	4	4	4	114	114
Denominator	38	38	38	344	344
Data Source					Data comes from the National Survey of CSHCN 2005
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be					

applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	35	36	37	38	38

Notes - 2008
Data comes from the National Survey of CSHCN 2005 - 2006.

Notes - 2007
Indicator data comes from the National Survey of CSHCN, conducted by HRSA and CDC, 2005-2006. Compared to the 2001 CSHCN survey, there were wording changes, skip pattern revisions, and additions to the questions used to generate the NPM06 indicator for the 2005-2006 CSHCN survey. There were also issues around the reliability of the 2001 data because of the sample size. The data for the two surveys are not comparable for PM #06 and the 2005-2006 may be considered baseline data. Our statewide survey mirrors the National Survey of CSHCN with a 33% response to question asking if there is a Transition Plan in place.

Notes - 2006
The data reported in 2006 are pre-populated with the data from 2005 for this performance measure.
This information was not address on the 2006 CSHCN Transition Survey

a. Last Year's Accomplishments
The program continued mail-out of a transition-focused survey to YSHCN in our database in the month of their 14th birthday. Survey responses generated contact between caseworkers and families on transition issues. CSHCN staff provided transition information by displaying at Transition Fairs and other meetings. Training was provided to all CSHCN staff over two days on transition issues such as education opportunities, economic assistance, job training opportunities and health care transition. Caseworkers have focused on providing information and education on transition, the changes to expect as the YSHCN ages and the services available for young adults related to health care, education, job training and independent living.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Transition surveys were received from 116 YSHCN with responses that assist the program in planning services.				X
2. CSHCN staff participated in AR Interagency Transition Partnership, a multi-agency committee working on transition issues.				X
3. CSHCN staff worked with individual YSHCN & local transition representatives to develop school transition plans.		X		
4. CSHCN staff worked in local Interagency Coordinating Councils to participate in Transition Fairs in the Dept of Education Regional Cooperatives.				X
5. Provided transition materials to all youth on our caseload receiving CSHCN services at age 14 years.		X		
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Transition survey is mailed to all individuals on the CSHCN database in the month of their 14th birthday. Surveys indicating that assistance is needed are forwarded to CSHCN staff for individual contact. CSHCN staff assist families of YSHCN in completion of DDS Alternative Community Services Home and Community Based Waiver applications and Aging and Adult Services Waivers for the Physically Disabled. Regional Managers monitor service plans to assess information and assistance provided on Transition topics.

c. Plan for the Coming Year
Develop newsletter article/series on Transition. Continue the Transition Survey. Target transition issues during Needs Assessment process.

Performance Measure 07: *Percent of 19 to 35 month olds who have received full schedule of age appropriate immunizations against Measles, Mumps, Rubella, Polio, Diphtheria, Tetanus, Pertussis, Haemophilus Influenza, and Hepatitis B.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	77.2	80	85	87	88
Annual Indicator	78.9	83.4	86.8	79.4	77.9
Numerator	3266	3269	3375	5848	6701
Denominator	4139	3921	3887	7363	8601
Data Source					Vaccines For Children Program Co-CASA
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	80	82	84	85	87

Notes - 2008
Change in percent complete age appropriate immunizations for 2008 reflect addition of participating VFC private providers that provided immunizations to Arkansas children 19 to 35 months of age.

2008 data are from the Comprehensive Clinic Assessment Software Application (Co-CASA) program from the Vaccines for Children (VFC) Program.

The denominator is the number of children sampled at local health units and participating VFC private providers. The numerator is the number of children with coplete vaccine recores from those sampled.

Notes - 2007
2007 data were changed to reflect addition of immunizations provided by participating Vaccines for Children (VFC) private providers.

2007 data are from the Comprehensive Clinic Assessment Software Application (Co-CASA) program from the Vaccines for Children (VFC) Program.

The denominator is the number of children sampled at the local health units. The numerator is the number of children with complete vaccine records from those sampled.

The data are from ADH local health units and do not include private providers.

a. Last Year's Accomplishments
For children 24 through 35 months of age seen in local health unit clinics and some private providers' offices, the 2008 age-appropriate immunization rate was 74.5%. The National Immunization Survey conducted by the National Immunization Program had Arkansas's immunization rates at 75.0% (CI plus/minus 5.9) for children seen in both public and private clinics. This ranking is below the national average of 80.1% and does not meet the 2010 Goal of 80% age-appropriate immunization rates for Arkansas' two year old children. While this survey is the basis for reporting two year old immunization rates, it is based on evaluating the immunization records of less than 200 children. The internal evaluation of the state's immunization rates is based on analysis of many more immunization records and is believed to better represent the actual rates.

The Immunization Section continually works to attract more providers utilizing the immunization registry to make a more comprehensive immunization data base with immunization records readily available to both providers and parents. The immunization registry is web-based and currently 100% of the 548 providers report immunization information on a real-time basis or via batch downloads using HL7 to the registry via computers in their offices.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Birth certificates for all babies were registered in the statewide Immunization Registry (IR).				X
2. Immunizations provided to the child, if any, during the newborn hospitalization were entered in the IR.				X
3. Through a collaborative program called "Vaccines for Children" the Health Department immunization clinics and primary care physicians' offices provided immunizations according to the national ACIP recommendations.			X	
4. Immunizations given in local health units and primary care physicians' offices were entered into the IR. Offices had direct on-line entry access or electronic upload capabilities.				X
5. Training continued for both public and private clinic staff and school nurses in data entry. Training for licensed childcare facilities has recently begun.				X
6. By comparison to birth records, the IR tracked the vast majority of children.				X
7. Recently implemented vaccines include human papillomavirus, rotavirus, meningococcal, and adult pertussis, all of which have been assigned a high priority in local health units.			X	
8. Public health offices used reminders and call-backs of local health unit clients (e.g., WIC infants) to assure completeness of immunizations received.		X		
9. IR reminder and recall capabilities were utilized.				X

10. As mandated by law, all immunizations given to individuals less than 22 years of age were reported to the IR by health care providers.				X

b. Current Activities

The Immunization Section, through ADH's 94 local health units, routinely offers all vaccines necessary to age-appropriately immunize children. Each local health unit provides all immunization services, and is able to identify children who are delinquent on needed doses of vaccine. Follow-up activities are initiated and designed to prompt parents/guardians to bring children into clinics to receive needed doses of vaccine. Additionally, the Immunization Section has Vaccines For Children (VFC) regional colleagues who promote immunization activities in private physicians' offices throughout the state. These activities include conducting an assessment of patients' immunization status and providing technical assistance on conducting follow-up activities with children to increase immunization rates. The Immunization Section, through the regional colleagues, continually solicits participation of all clinics, both public and private, to participate in the VFC Program therefore enabling the Department of Health to expand availability of services across Arkansas. The web-based immunization registry greatly enhances overall service delivery activities. It allows public and private providers quick access to their patients' immunization records and real-time updating of individual immunization records. The Immunization Registry Team places priority on training and recruitment of additional providers utilizing the registry.

c. Plan for the Coming Year

The Immunization Section has recently implemented the use of newly licensed vaccines for use in ADH's immunization clinics such as the human papillomavirus (Gardasil), rotavirus, meningococcal (Menactra) and adult pertussis (Tdap). The use of these new vaccines will be a high priority in ADH's local health units in an effort to reduce morbidity and mortality associated with these diseases.

The Immunization Section will continue to promote immunization of Arkansas' children through the Vaccines For Children (VCF) Program. The Section will identify areas in the state that have low immunization rates and intensify efforts to immunize individuals delinquent on receiving needed vaccines. The Immunization Registry Team will continue to promote utilization of the web-based registry. The regional colleagues will continue to promote participation of all immunization providers in the VCF Program. Clinics will be assessed routinely to determine the age-appropriate immunization status of the children they serve so that steps can be taken to increase immunization rates. The Section will also stay abreast of activities in other states and will implement those activities that have been proven to increase immunization rates.

Performance Measure 08: *The rate of birth (per 1,000) for teenagers aged 15 through 17 years.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	36	28	28	31	32
Annual Indicator	30.4	29.0	30.5	30.8	30.2
Numerator	1715	1661	1796	1813	1780
Denominator	56502	57234	58842	58877	58877
Data Source					2008 Birth Certificates
Check this box if you cannot report the					

numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	29.5	29	29	28.5	28.5

Notes - 2008
2007 female population 15-17 years was used to compute 2008 rate.

The Abstinence Education and Unwed Birth Prevention activities, which are aimeed at teen pregnancy prevention, have been significantly cutback due to reductions in state and other funding. In addition, the Federal funds for abstinence education have been harder to utilize due the uncertainty and delayed disbursement of the funds from the federal government.

Notes - 2007
The Abstinence Education and Unwed Birth Prevention activities, which are aimeed at teen pregnancy prevention, have been significantly cutback due to reductions in state and other funding. In addition, the Federal funds for abstinence education have been harder to utilize due the uncertainty and delayed disbursement of the funds from the federal government.

Notes - 2006
Used 2005 population estimate 15-17 years for 2006 indicator.

a. Last Year's Accomplishments
The Arkansas Department of Health continues to view teen pregnancy rates as a priority within our strategic plans to improve health outcomes and reduce disparities. Local Health Units offer family planning services in every county. Last year, the Center for Local Public Health continued to implement programs to expand the number of family planning users with a focus on teens and high risk populations. The Title X program is designed to provide access to contraceptive services, supplies and information to all who want and need them. By law, priority is given to persons from low-income families. In CY 2008 the LHU's served 19,401 females and males under 20 years old for family planning services. Clients under age 20 totaled 25.5% of all family planning users. Efforts by each county's local health units include a standard of a minimum of two outreach efforts each year that focus on hard-to-reach populations. Outreach activities coordinated by the Local Health Units included pregnancy prevention presentations in schools, recognition of National Birth Defects Prevention Month, local coalitions of Teen Pregnancy Committees, parent/student events with concentration on pregnancy prevention, and other teen pregnancy prevention events throughout the state. Sub grants for Unwed Birth Prevention provided funds for four county coalitions to develop pregnancy prevention and education activities. The coalitions' activities reached teens in schools, after school activities/clubs and faith based organizations. Technical assistance was provided.

The Black Entertainment Television,General Mills, and Philander Smith College co-sponsored a Women's Health Symposium in Little Rock.

The Abstinence Education Program (AEP) funded 10 community projects, (schools, faith, and community-based organizations) throughout the state, targeting youth ages 12 to 29 years, during the last federal fiscal 2007 and 2008 years. During federal fiscal years 2003-2007, the sub-grants participated in a health-behavioral research evaluation. The evaluator, Institute for Research and Evaluation (IRE), for 5 years, provided regular reports on the overall evaluation and by project. Technical assistance was provided to all active sub-grantees during those years. An Interim Report received May 2007 revealed that positive improvements among students receiving

abstinence education were noted during the time the abstinence education activities were received. However, twelve months after the close of the intervention, the students' reported knowledge, attitudes, and behavioral intentions were not measurably different from comparison peers. Improvement in students' attitudes and intentions toward sexual activity reverted back to where they were before they started the program.

During State Fiscal Year 2008, the ADH utilized State General Revenue along with federal funds to help support abstinence education program activities.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Abstinence Education Programs were conducted in 6 sites, funded by a combination of ACF grant and state funds by ADH.		X		
2. Teen birth rates were published on the ADH internet web site.				X
3. Title X family planning clinics in 91 local health units provided free or reduced cost family planning services. ADH family planning clinics were located in every county in Arkansas.			X	
4. ADH Hometown Health Initiative's activities included family planning outreach to teens and hard-to-reach populations.		X		
5. Unwed Birth Prevention projects to develop pregnancy prevention and education activities were carried out in four counties.		X		
6. Family planning traveling teams funded by Title X were established for the NE Region in an effort to expand services and increase the number of family planning clients, with a priority of teens and high risk populations.			X	
7. Family Planning appointment reminders were mailed to clients that were past due for their annual exams.		X		
8.				
9.				
10.				

b. Current Activities

The Agency is requesting funding to provide for the continuation of the Unwed Birth Prevention sub grants. ADH, Women's Health, provides funding and technical assistance to support the Home Town Health Initiatives (HHI). The HHI's activities include outreach to teens and hard to reach populations. This year the HHI is providing "National Teen Pregnancy Prevention" assistance and promotional materials to the LHU's. The Family Planning program has been provided Title X funds to provide outreach efforts to increase family planning users, specifically teens and low income people. Title X funds also support the family planning activities of Ouachita Children's Center and Wilbur D. Mills Substance Abuse Program. ADH Family Planning efforts have included a family planning outreach flyer to be used to reach a population that might be unaware of their LHU's family planning services. The Southeast Region has billboards advertising services family planning services.

Currently, there are 6 sub-grants for the AEP. In August 2008, the State submitted an application for the Title V AEP for FY 2009-2013. In December 2008, the State received notification of award only through June 30, 2009, three months short of the federal grant year. For State FY2009, ADH continued to use State General Revenue to assist in supporting the AEP in Arkansas.

c. Plan for the Coming Year
Plans are for the Family Planning Program to continue to expand efforts at outreach to teenagers through the local health units in each county. Women's Health will work with the Center for Local Public Health to facilitate family planning appointment reminders for all family planning clients needing their annual exams. ADH will work with the Unwed Birth Prevention sub grantees, as well as the Title X sub grantees at Ouachita Children's Center and Wilbur Mills Substance Abuse Program in their efforts to reach teens and other high risk populations. ADH continues to monitor and evaluate the Family Planning Program per Title X requirements.

Funding for the Unwed Birth Prevention Programs is uncertain after June 30, 2009.

Currently, the federal Abstinence Education funding is uncertain after June 30, 2009. The Title V 510 AEP ends June 30, 2009, unless Congress re-authorizes the program.

For the current 6 AEP sub-grantees, monitoring and tracking along with process evaluation and data collection are continuing. Based on the two-year data analysis and evaluation by IRE and current research, the Arkansas AEP will emphasize to current and future sub-grantees to provide 14 or more hours of abstinence education to the target population, encourage that sub-grantees offer multiple opportunities for youth to attend abstinence education activities, and request sub-grantees that are not serving middle school youth to submit a plan for continuing service or implementing follow-up for youth beyond the middle school years. The ADH plans to utilize the Epidemiology Section to assist with the evaluation, in particular tracking and monitoring sub-grantees to determine if 14 hours or more of direct abstinence education is provided to clients served.

Performance Measure 09: *Percent of third grade children who have received protective sealants on at least one permanent molar tooth.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	29	30	16	18	19
Annual Indicator	15.0	15.0	15.0	15.0	17.0
Numerator	1071	1071	656	197	206
Denominator	7138	7138	4376	1312	1214
Data Source					Oral Health Branch, ADH
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	18	19	20	21	22

Notes - 2008
A statewide dental screening survey was not conducted in 2008. Results are limited to dental screenings done by request of a local agency or organization.

Notes - 2007

A statewide dental screening survey was not conducted in 2007. Results are limited to dental screenings done by request of a local agency or organization.

Notes - 2006
A statewide dental screening survey was not conducted in 2006. Results are limited to "conveinence samples" which are dental screenings done by request of a local agency or organization. Hence, the smaller numbers in the denominator and numerator cells.

a. Last Year's Accomplishments
Many programs of the Office of Oral Health (OOH) are funded by the Centers for Disease Control and Prevention to augment the state oral health program. Under the Chronic Disease Prevention grant of $368,745, the OOH is building infrastructure and capacity within the State Oral Health program, supporting the Arkansas Oral Health Coalition, Inc. and expanding or creating effective programs to improve oral health outcomes and reduce disparities.

CDC grant funding has provided for additional staff, including the recent addition of a state sealant coordinator. The grant also provided funds to better assess oral health in Arkansas, to design new programs on dental sealants, tobacco cessation and prevention, and family violence prevention. The Office of Oral Health, working with various community leaders, has increased community water fluoridation in Arkansas to 65% of those people on water systems.

Working alongside the Arkansas Oral Health Coalition, OOH continued to support dental sealant programs in the state. With funding from the Daughters of Charity Foundation, OOH embarked on a three-year program leading to the "Seal the State in 2008" project. Through this project, dental sealant awareness programs have occurred in all 75 counties along with direct services for 2,000 at-risk children. Together with comprehensive dental care provided by contract dentists, dental hygiene students from UAMS rotated through a school-based weekly clinic in Little Rock that ADH and partners formed, providing dental sealants to more than 500 children. In western Arkansas, a project in collaboration with Health Connections and UAMS Dental Hygiene Program provided dental sealants to almost 300 students.

Other initiatives include numerous presentations on family violence prevention presented to various health care professionals, Head Start agencies and lay audiences. Also, the successful Spit Tobacco Prevention Night with the Arkansas Travelers' minor league professional baseball team -- based on the slogan, "Spit Tobacco: Chew, Dip and Die," is now in its eighth year. Head Start dental exams are performed when requested by Head Start staff.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. In recent years the Oral Health Program has conducted oral examinations of children in third grade in a randomly selected group of schools in the state. This survey is expensive and is not done every year.				X
2. Through the Seal the State project, several initiatives to provide sealants to children around the state have taken place and will continue in partnership with other programs and agencies.				X
3. The importance of oral health care has been repeatedly emphasized in community based projects. Tee shirts, tooth brushes, and other premiums have been distributed in many communities throughout the state.		X		
4. The annual Governor’s Summit on Oral health was held, with				X

an attendance rate of about 100 dentists, dental hygienists, dental assistants, and other interested parties.				
5. A statewide Oral Health Advisory Council remained active.				X
6. In addition to the issue of protective sealants, the Office of Oral Health continued to advocate for and assist communities in fluoridation of public water systems.				X
7. Dr. Mouden remained very active in attending municipal and county meetings regarding the decision to fluoridate water supplies.				X
8. The Health Connections Section of ADH has developed a contract with Medicaid to establish more positions for the ConnectCare telephone helpline to link Medicaid recipients to dentists throughout the state.		X		
9.				
10.				

b. Current Activities
The OOH continues to assess oral health across Arkansas, including open mouth surveys for children, adults and the elderly.

Year two of Seal the State was held in 15 Arkansas schools, delivering dental sealants to approximately 2,000 children. In addition, the awareness media campaign reached all 75 Arkansas counties with information about the importance of dental sealants.

Oral health workforce initiatives include funding dental recruitments efforts by Delta Dental of Arkansas, providing Grants-in-Aid to new dentists practicing in underserved areas, promoting dental careers in minority and rural populations, promoting language translation services in dental offices, and increasing awareness on family violence prevention.

The CDC grant supports the "Governor's Oral Health Summit," now in its eighth year. The grant also provided additional support for improving the community water fluoridation program in Arkansas. The grant funds educational opportunities to further acceptance of fluoridation among policy makers, health care professionals, civic leaders, water plant personnel, and citizens, all based on the slogan, "Got Teeth? Get Fluoride!"

The Health Connections Section of the Arkansas Department of Health has developed its ConnectCare contract with Medicaid to establish more positions for the ConnectCare telephone helpline to link Medicaid recipients to dentists throughout the state.

c. Plan for the Coming Year
The OOH is in its second year for the Seal the State project. The grant will help increase awareness about the importance of dental sealants and encourage more dentists and dental hygienists to provide this important service.

Expansion of community water fluoridation continues to be a major focus for the OOH.

Tobacco prevention, injury prevention and family violence prevention are all focus areas for educating healthcare professionals and lay audiences.

Performance Measure 10: *The rate of deaths to children aged 14 years and younger caused by motor vehicle crashes per 100,000 children.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	10.3	7	4.2	6	6
Annual Indicator	7.3	5.7	7.5	5.7	4.0
Numerator	41	32	43	33	23
Denominator	565382	557472	569943	579442	579442
Data Source					2008 Death Certificates
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	3.9	3.8	3.7	3.7	3.7

Notes - 2008
2007 population estimate 0-14 years was used to calculate 2008 rate.

The 2008 data are lacking deaths that occurred to Arkansas residents in other states. Interstate exchange agreements between states guarantee death certificates to Arkansas from other states, but the process may be prolonged.

In addition, death certificates may be delayed due to causes of deaths pending by County Coroners or the medical examiner.

These two circumstances above may ultimately result in a higher mortality rate than is reported for 2008.

Notes - 2007
2007 death data are provisional.

The 2007 data are lacking deaths that occurred to Arkansas residents in other states. Interstate exchange agreements between states guarantee death certificates to Arkansas from other states, but the process may be prolonged.

Notes - 2006
Used 2005 population estimate 0 - 14 years for 2006 indicator.

a. Last Year's Accomplishments
Arkansas's children have long been at increased risk of death from all causes of injury, partly due to lack of a statewide trauma system. This past year, ADH was one of the lead agencies in a coalition formed to promote establishment of such a system. These efforts came to fruition with

passage of Act 180 in the 2009 legislative session, which includes funding for a Level I trauma center in Little Rock. The new trauma system will reduce response time for EMS to transport injury victims to appropriately staffed and equipped medical facilities. In support of the enabling legislation, ADH participated in a number of media events sponsored by partners in the coalition, including the University of Arkansas for Medical Sciences, Arkansas Children's Hospital, Arkansas Hospital Association, Arkansas Farm Bureau, and Mothers Against Drunk Driving.

ADH also rallied behind several bills related to motor vehicle safety. These include the change in the seat belt law from secondary to primary enforcement; the institution of graduated driver's licensing for youth 16-18 years old (imposing restrictions on driving times and allowed passengers for novice drivers); the prohibition for young drivers (<18 years) on use of hand-held cellular phones while driving; and the prohibition of text messaging while driving for all drivers in the state. Significantly, and due in no small measure to state partners in injury prevention, all of these proposals were enacted into law during the 2009 legislative session. Collectively, these acts should dramatically reduce motor vehicle injury deaths not only for children and adolescents, but for all Arkansans.

The ADH Injury Prevention and Control Branch continued to work statewide to provide injury data and educational materials through local community and civic projects, health fairs, in-service trainings, and Hometown Health Improvement Coalitions. The Branch also collaborated with the Arkansas Safe Kids Coalition in injury prevention public awareness events. Hometown Health Improvement (HHI) Coalitions collaborated with Arkansas Safe Kids and Arkansas Children's Hospital on a number of child safety seat check-up events around the state. HHI Coalitions typically include retailers, school representatives, local government officials, and faith-based organizations, along with various local health providers.

The Child Passenger Safety (CPS) program housed at Arkansas Children's Hospital offered a number of CPS Technician Certification Courses around the state. These trainings are targeted to interested local volunteers (often hospital personnel, EMT's, police, and firefighters), who upon completion are then qualified to perform safety seat check-ups in their home communities.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. ADH was a leading member of a coalition which (successfully) promoted a law establishing a statewide trauma system.				X
2. ADH supported several passenger protection measures, including a primary enforcement seat belt law, graduated driver's licensing, a ban on cell phone use by younger drivers, and a ban on text messaging while driving.				X
3. ADH Injury Prevention and Control collaborated with Arkansas Safe Kids, Hometown Health Coalitions, and Arkansas Children's Hospital to disseminate injury prevention educational materials through various events and locations			X	
4. The Child Passenger Safety Program at Arkansas Children's Hospital sponsored CPS technician certification training at a number of sites				X
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
In conjunction with many stakeholders, the Emergency Medical Services Section at ADH is now moving forward with the process of establishing a statewide trauma system. The various passenger safety laws passed in thelast session go into effect July 1, 2009.

The Injury Prevention and Control Branch continues to collaborate with Hometown Health, Arkansas Safe Kids, and other groups in promoting child passenger safety and other safety measures. Safety seat check-ups and CPS certification courses continue to be provided regularly under the Arkansas Children's Hospital program.

c. Plan for the Coming Year
The Injury Prevention and Control (IP&C) Branch anticipates continuing to work with communities, schools, faith-based groups, and various standing coalitions to provide injury-related data and technical assistance. The IP&C Branch expects that a permanent Branch Chief will be hired in the upcoming year. This individual will be required to possess research skills and have a background in injury prevention. Although the new Chief will have to define priorities after he or she is hired, childhood injury (particularly motor vehicle crash-related) is expected to be a strong focus of the Branch.

Family Health will monitor implementation of all the recently enacted laws, and partner as needed with EMS, ACH, HHI, and/or the Injury Prevention Branch in all aspects of injury prevention activities. Family Health will of course also closely monitor health statistics related to children injured or killed motor vehicle crashes to help gauge the impact of these important policies in Arkansas.

Performance Measure 11: *The percent of mothers who breastfeed their infants at 6 months of age.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			14	25	26
Annual Indicator		13.6	24.6	23.4	26.4
Numerator		3425	8960	8913	10147
Denominator		25095	36481	38017	38428
Data Source					2007 PRAMS survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	27	28	28	29	30

Notes - 2008
2008 data are from the 2007 PRAMS survey.

Denominator is total (weighted) number of women surveyed in 2007.

Numerator is total (weighted) number of women who responded 'Yes" to the question, "Are you still breastfeeding or feeding pumped milk to your new baby?" on the 2007 PRAMS survey.

The age of babies of PRAMS respondents ranges from 2 months to 9 months with the majority occurring around 4 months. This may lead to a possible overestimation of mothers breastfeeding their babies at 6 months of age.

Notes - 2007
2007 source is 2006 PRAMS survey.

Denominator is total (weighted) number of women surveyed in 2006.
Numerator is total (weighted) number of women who responded 'Yes" to the question, "Are you still breastfeeding or feeding pumped milk to your new baby?" on the 2006 PRAMS survey.

The age of babies of PRAMS respondents ranges from 2 months to 9 months with the majority occurring around 4 months. This may lead to a possible overestimation of mothers breastfeeding their babies at 6 months of age.

Notes - 2006
2005 data was percent of WIC mothers that breastfed their infants at 6 months of age.
2006 source is 2005 PRAMS survey.
Denominator is total (weighted) number of women surveyed.
Numerator is total (weighted) number of women who responded "Yes" to the question, "Are you still breastfeeding or feeding pumped mild to your new baby?" on the 2005 PRAMS survey.
The age of infants ranges from 2 months to 9 months.

a. Last Year's Accomplishments
During the year, the fourth annual Breastfeeding Seminar: A Course for Health Professionals was offered by the WIC program for continuing education hours for nurses, dietitians, home economists and breastfeeding counselors. Competency based breastfeeding self-study training modules for WIC professionals and support staff was also offered through A-Train (CEU hours were approved for professional staff).

USDA Southwest Region states continued the breastfeeding education bag collaborative project. Arkansas distributed 17,000 education bags in 50 counties as part of the required nutrition education-breastfeeding promotion to pregnant women at the initial WIC certification. Funding has been received to continue the bag project for the next fiscal year.

A toll-free Breastfeeding Helpline was operational. Each Health Unit has an onsite breastfeeding contact person to coordinate the local breastfeeding support and promotion plan. Local Health Unit staff maintained a clinic environment that endorsed breastfeeding. For example, there is a requirement that no formula displays or items displaying formulas or company names can be displayed. Areas are designated for moms who want or need to breastfeed. Each Local Health Unit provided at least one breastfeeding promotion project for the year, which included health fairs, lobby or clinic displays, and participation in World Breastfeeding Week displays.

Review of national data suggests breastfeeding peer counselors as a resource to mothers make significant contributions to breastfeeding rates. The ADH WIC program continues to seek funds to expand the peer counselors' effort. An additional two peer counselors positions were approved and will be filled this fiscal year.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service

	DHC	ES	PBS	IB
1. WIC, during certification of pregnant women, provided breast feeding education for all participants.		X		
2. Throughout pregnancy, WIC counselors revisited this issue with pregnant women to reinforce their knowledge of the specifics of breastfeeding.		X		
3. WIC policy in local health units required that the unit environment be breastfeeding "friendly," including posters and brochures readily available to clients. In addition, commercial advertising for formula products is minimized in health units.				X
4. The WIC program pursued funding for additional breastfeeding peer counselors.		X		
5. Arkansas participated in an expanded project targeting pregnant women in the Southwest USDA Region.			X	
6. WIC breastfeeding experts conducted trainings for health professionals throughout the state, including hospital personnel, nutritionists, nurses, lactation specialists, and breastfeeding peer counselors.				X
7. A monthly breastfeeding "Quick Notes" newsletter was sent to all WIC staff through the local health unit breastfeeding contacts.				X
8.				
9.				
10.				

b. Current Activities
The above activities continue.

A monthly breastfeeding "Quick Notes" newsletter is sent out to all WIC staff through each Local Health Unit breastfeeding contact.

Breastfeeding rates are provided to Local Health Units on a monthly basis.

c. Plan for the Coming Year

The Fifth Annual Breastfeeding Seminar: A Course for Health Professionals will be made available to 75 health professionals statewide. The course is co-sponsored by the Arkansas Department of Health-WIC, Arkansas Children's Hospital and the University of Arkansas for the Medical Sciences, College of Medicine.

Capturing data on breast-feeding activity at 6 months of the baby's age can be done only for WIC patients. However, PRAMS data surveys women in the 2nd to 4th month after a delivery. That data has provided a more population-wide view of breastfeeding practices, a picture that is quite different from the behavioral choices of women on WIC. We prefer to present data on breastfeeding progress taken from PRAMS data, which means the definition of the measure would have to change from 6 months to "at the time of the PRAMS survey."

Performance Measure 12: *Percentage of newborns who have been screened for hearing before hospital discharge.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	75	97	97.9	98.3	98.4
Annual Indicator	96.5	97.8	98.2	98.2	99.0
Numerator	35059	36789	37866	38978	38468
Denominator	36348	37610	38573	39682	38865
Data Source					ADH Infant Hearing Program
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	99	99	99	99	99

Notes - 2008
Denominator is number of forms received from hospitals (38,865). Numerator is number of infants (reported on forms) that received hearing screens (38,468).

Notes - 2007
Denominator is number of forms received from hospitals (39,682). Numerator is number of infants (reported on forms) that received hearing screens (38,978).

Notes - 2006
Denominator is number of forms received from hospitals (38,573). Numerator is number of infants (reported on forms) that received hearing screens (37866).

a. Last Year's Accomplishments
The Infant Hearing Program (IHP) and the Information Technology Services (ITS) at the Arkansas Department of Health collaborated on an expansion of ad hoc reporting capability through Business Objects software. The enhancements were centered on reporting information necessary for state tracking needs of newborn/infants needing follow-up hearing screening and diagnostic testing and necessary reporting criteria for the Centers for Disease Control and Prevention (CDC). Additionally, the program's website was revised to include separate sections with specific information for different stakeholders involved with Early Hearing Detection and Intervention (EHDI) in the state (i.e. physician section, audiologist section, parent section, etc.). The revision also included a comments page and a supplies-ordering page for parents' and hospitals' feedback and ease of contact.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Universal hearing screening in the hospital of birth is mandated by state law. Only hospitals delivering less than 50 babies per year are exempted. Lay midwives are also required to arrange for hearing screens.			X	
2. The hospitals were provided with TA in physiologic testing and				X

equipment purchase and a four-part form for documenting the hearing screen results.				
3. A database was kept at ADH, populated with birth certificates and matched for each baby. Monthly data reports were sent to the reporting hospitals.				X
4. Abnormal reports were identified and physicians and parents were notified of the need for follow-up testing. Telephone calls with both physicians and parents were made when necessary to assure this follow-up.			X	
5. Confirmatory audiologists' testing results were reported to the database.			X	
6. The program was guided by an advisory council of experts.				X
7. The program worked with Early Intervention (Part C) to assure needed services for children with diagnosed hearing loss.		X		
8. A needs assessment was developed and conducted by an outside entity to identify challenges in the initial screening and follow-up testing of failed hearing screens.				X
9. The program began working with VR/Health Statistics to link the data input with the new Electronic Birth Certificate being planned. The software vendor has been chosen and the functional requirements are almost complete for design of the linkage.				X
10.				

b. Current Activities

The Infant Hearing Program (IHP) has collaborated with the University of Arkansas at Little Rock, Institute of Government, to develop and perform a Needs Assessment to identify challenges in the initial screening and follow-up testing of infants' hearing, as well as to suggest recommendations for program improvement. Major recommendations from this report include: 1) Parents, physicians, and the birthing hospitals must share the responsibility for follow-up, 2) Care providers and parents should examine and improve communications to increase the likelihood that an infant will be returned for retesting, 3) Education of parents must be emphasized, 4) Better reporting by hospitals and information-sharing by ADH, 5) ADH should work with care providers to improve services, 6) Hearing testing equipment must be available and in functioning order, and 7) Further research on roles of family care physicians, audiologists, ENTs, and parents.

The IHP will host five (5) regional meetings for stakeholders across the state to broaden the outreach activities. After all regions have been assessed, the challenges and recommendations identified will be used for program goals toward improvement for follow-up testing.

The IHP has also worked with the Vital Records/Health Statistics Section of ADH to link IHP data input with the Electronic Birth certificate (EBC). The software vendor has been chosen and functional requirements are almost complete for the design of the linkage.

c. Plan for the Coming Year

The Infant Hearing Module and the Electronic Birth Certificate link will continue as a major focus for the coming year. A tentative schedule for the Electronic Vital Records Event (including the Infant Hearing Module) estimates December 2010 as the completion date. The IHP will be able to collect additional demographic data and other vital data information that is unavailable to the program currently. The revision to an electronic format should allow the data from hospitals to be received by the state office in a timelier manner than the program's current paper-based system.

In addition, the Universal Newborn Hearing Screening, Tracking and Intervention Advisory Board will identify a task force committee to look at the revision to the state guidelines that were developed subsequent to the Rules and Regulations of the state hearing screening mandate, Act 1559 of 1999. The task force will review existing guidelines and incorporate the 2007 Joint Committee on Infant Hearing's recommendations as appropriate.

A Memorandum of Agreement (MOA) is under development and will be signed into action in the coming year which will allow reciprocal sharing of data between the Early Hearing Detection and Intervention (EHDI) Program and Part C, Early Intervention Services.

Performance Measure 13: *Percent of children without health insurance.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	10	7	7	10.8	10.8
Annual Indicator	6.8	10.7	9.3	9.3	6.2
Numerator	47000	72000	65000	65167	44425
Denominator	692000	673000	699000	698812	719784
Data Source					US Census Bureau
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	6	5.5	5	4.5	3.5

Notes - 2008
2008 indicator populated with 2007 data.
Data source: U.S. Census Breau, Current Population Survey, Annual Social and Economic Supplement, 2008

Notes - 2007
2007 indicator populated with 2006 data.
Data source: U.S. Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2007

Notes - 2006
2004 - 2006 data are estimates. Source: U.S. Census Bureau, Current Population Survey, 1988 to 2006 Annual Social and Economic Supplements.

a. Last Year's Accomplishments
The Arkansas Finish Line Coalition, composed of a large number of health, social service, and education organizations, conducted a campaign to promote a variety of measures related to health coverage for children. These included expansion of Medicaid to more children, creation of electronic enrollment and re-enrollment systems, continuous coverage for children served under traditional Medicaid (ARKids A), and creation of a buy-in option for families just over the income

limit. The Coalition, which was staffed by Arkansas Advocates for Children and Families, received broad attention and support for its efforts.

Before and during the 2009 Arkansas General Assembly, ADH participated in another coalition in support of a tax on tobacco products. This tax was passed into law as Act 180, and provides, among other health initiatives, an expansion of Medicaid benefits to 250% of the federal poverty level. While at least 8,000 children will benefit directly from the expansion, it is also projected that up to 12,000 additional children already eligible for AR Kids under the existing criteria (200% FPL) will also now become enrolled. This phenomenon has been noted in other states, and is attributed to increased awareness and diminished social stigma following an expansion of public health insurance to moderate-income families.

The Health Connections Section (HCS) Health Educator staff, funded through the Medicaid ConnectCare contract, provided Health Education/Promotion/Outreach, working collaboratively with schools, Head Starts, Hometown Health, local health units and other local organizations. In an effort to encourage enrollment, particular emphasis was placed in areas of the State with a high Medicaid eligible population. The Health Educator staff continued establishing their role as a resource to support school based Human Service workers. Partnering with Coordinated School Health, the second annual fall Human Service worker workshop was held. The workshop provided information on available resources, types of support/assistance available to Medicaid recipients, Medicaid application process, preventive health information, and opportunities for networking and coordination. The Health Educator staff produced a variety of newsletters brochures, and other written materials addressing such concerns as prenatal care, WIC, immunizations, newborn screening, tobacco use and obesity.

HCS staff, also funded through the Medicaid ConnectCare contract, operated the ConnectCare telephone Helpline from 6 a.m. Monday through 10 p.m. Friday to assist Medicaid/ARKids First recipients with locating and assigning a primary care physician and to provide resource information. A ConnectCare website is maintained at www.seeyourdoc.org. This website serves as a source for Medicaid/ArKids First to request a primary physician assignment or change.

The HCS additionally serves as a resource for general health information. An Arkansas Health information telephone helpline operational 8 a.m. to 4:30 p.m. Monday through Friday provides callers with information regarding prenatal care (Campaign for Healthy Babies), smoking cessation (Clean Indoor Air), WIC, immunizations, and numerous other requests for health resource information and accessing services.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The Finish Line Coalition broadly promoted health coverage initiatives including expansion of Medicaid eligibility, creation of electronic systems, continuous coverage for ARKids A recipients, and creation of a buy-in option.				X
2. Act 180 was passed (tax on tobacco products), which included provision for expansion of Medicaid eligibility to 250% FPL.				X
3. The Health Connections Section within Family Health provided promotion and outreach involving schools, Head Starts, Hometown Health Improvement, local health units and other local groups to encourage Medicaid enrollment.		X		
4. Health Connections health educators served as resources to school-based Human Service Workers.				X
5. Health Connections staff partnered with Coordinated School				X

Health to present a state-level workshop for Human Service Workers.				
6. Health Connections personnel operated a helpline to assist Medicaid/ARKids First recipients with finding a primary care physician, and to provide other resource information as needed.		X		
7.				
8.				
9.				
10.				

b. Current Activities

The Finish Line Coalition continues to pursue its goal of expansion of Medicaid benefits to 300% of the FPL. The group also remains very interested in implementing a buy-in option, in presumptive enrollment for children who appear to be eligible, and in electronic enrollment and re-enrollment systems development. Discussions between the state Medicaid program and key stakeholders around these subjects are ongoing, and programmatic refinements that further reduce the already dwindling percentage of uninsured children should ensue.

HCS activities outlined above continue this year. HCS is intensifying health education/promotion/outreach efforts to schools and Human Service Workers based in schools with a high Medicaid eligible population by identifying local resources and facilitating resource coordination. HCS is developing its contract with Medicaid to establish more positions for ConnectCare to link Medicaid recipients to primary care physicians and dental care throughout the state. The Section is beginning preparation to expand Dental Coordination services to include adults beginning July 1, 2009.

c. Plan for the Coming Year

ADH will continue to partner with the state Medicaid agency, Arkansas Advocates for Children and Families, and all the other Finish Line organizations to move toward the goal of coverage for 100% of children. Given the current momentum in the state and the favorable political climate, this goal is realistically attainable within the next few years.

The Health Connections Section will continue those activities listed under "current year activities" above.

HCS will build relationships with WIC, immunizations, tobacco, and dental health to assure that during contact to set up a PCP assignment, that contact is used to provide other key health care information related to prenatal care, smoking cessation, dental care, well child care and other preventive health issues. HCS will also assist adult Medicaid recipients with dental appointments and coordinated dental care.

Performance Measure 14: *Percentage of children, ages 2 to 5 years, receiving WIC services with a Body Mass Index (BMI) at or above the 85th percentile.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			12.9	12.9	12.9
Annual Indicator		12.7	12.6	15.8	15.9
Numerator		3893	4159	5590	6136
Denominator		30655	33008	35378	38591
Data Source					2008 WIC-PEDNSS

Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	15.5	15	14.5	14.5	14

Notes - 2008
The majority of children receiving WIC services are preschool age children.
Data are from the PEDNSS report provided by CDC.

Notes - 2007
The majority of children receiving WIC services are preschool age children.

a. Last Year's Accomplishments
As in the past, children participating in WIC were prescribed food packages based upon age, but tailored to fit individual needs. All participants received nutrition education designed to address immediate concerns and improve overall health. In addition, one-on-one nutrition counseling with a registered dietician regarding specific nutrition-related health problems continued to be available in local health units.

WIC also carried out the Farmers' Market Nutrition Program, the mission of which is to encourage the consumption of fresh fruits and vegetables, and encourage development of farmers' markets. Women and children residing in counties with farmers' markets were eligible to receive food coupons which could be redeemed for fresh produce.

The WIC Program implemented a new MIS -- Successful Partners in Reaching Innovative Technology (SPIRIT). This project was funded by the USDA Food and Nutrition Service. SPIRIT is a State Agency Model (SAM) designed to reduce paperwork, improve program integrity and security, improve data accuracy, state efficiency and productivity and reduce system support and maintenance issues.

The Program also successfully implemented the Value Enhanced Nutrition Assessment (VENA). VENA takes a positive approach based on desired health outcomes rather than deficiencies. VENA's emphasis is to improve the current assessment practices by promoting a positive, client-centered approach to obtain information that is used to:

-determine nutrition eligibility
-provide individualized nutrition education
-tailor food package
-make appropriate referrals

WIC began making plans to implement the Interim Food Package rule, which will provide fruits and vegetables (fresh and frozen), whole grains (bread, tortillas, brown rice), and soy beverages. The rule must be implemented by October, 2009.

Training provided to WIC field and state office staff included Rapport Building and Communication Skills-Critical Thinking.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The WIC program successfully implemented the Value Enhanced Nutrition Assessment.			X	
2. The WIC program implemented a new management information information system (SPIRIT).				X
3. WIC trained state and local staff in rapport-building and communication skills/critical thinking.				X
4. WIC participants received food packages tailored to age and individual needs.		X		
5. WIC conducted the Farmers' Market Nutrition Program, which provided fresh produce to participants in selected counties.		X		
6. WIC participants received general nutrition education, and one-on-one nutritional counseling as needed for specific health issues.		X		
7.				
8.				
9.				
10.				

b. Current Activities
WIC continues the activities described above.

Local health unit staff training related to the implementation of the Interim Food Package Rule is progressing. "WIC Food Packages: Making the Change Work" is an interactive approach to assisting WIC Competent Professional Authorities (CPAs) in assessing participants to prescribe appropriate food packages and nutrition education. In addition, clerical staff will receive training regarding their role.

Implementation and training on the new management information system continues.

c. Plan for the Coming Year
1. Continuation of current activities as described.

2. Assessment and drafting of new policy for the new WIC food package. The Interim Food Package Rule was released by USDA in December of 2007 with mandatory implementation by October 1, 2009. Arkansas is participating in several work groups to determine issues that must be addressed such as gathering product information from food manufacturers; determining systems changes; anticipating steps to implement.

Performance Measure 15: *Percentage of women who smoke in the last three months of pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			18.4	20.9	20.7

Annual Indicator		18.5	20.9	19.4	18.8
Numerator		6339	7552	7326	7099
Denominator		34339	36160	37683	37857
Data Source					2007 PRAMS Survey
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	18.5	18.2	17.8	17.6	17.3

Notes - 2008
2008 data are from the 2007 PRAMS survey.

Notes - 2007
2007 data source is 2006 PRAMS survey.

Notes - 2006
2006 data source: 2005 PRAMS survey

a. Last Year's Accomplishments
Beginning October 1, 2008, the Arkansas Tobacco Quitline began operating through Free & Clear, Inc. The Stamp Out Smoking telephone line and fax back referral was in place Jan-Sept. 2008. As one of the nation's leading tobacco cessation treatment providers, Free & Clear's Quit for Life Program will help ADH expand our cessation services. Two toll free numbers and a fax referral program will be offered. Women who are pregnant are eligible for a specialized cessation program with additional benefits.

All maternity, family planning, WIC and STD clients seen in the ADH's local health units are screened for tobacco use. This is a required question in the history and counseling components of the Women's Health and WIC programs. Women's Health Programs include up to date smoking cessation policies as guidelines for the Public Health Nurse, ADH Nurse Practitioners and Clinicians utilize the UAMS ANGELS tobacco dependence/cessation guidelines for pregnant, postpartum and family planning clients. Programs provide written information English or Spanish on the risks of smoking and information on resources for cessation. ADH encounter management system (Business Objects) reported smoking cessation education on 1261 encounters for maternity clients. Clients receive education on the effects of tobacco/smoking in pregnancy and the identification of this as a preconception risk.

PRAMS provides data for Arkansas state health officials to use to improve the health of mothers and infants. Provisional 2007 PRAMS data reports 31.2% of Arkansas women smoked in the 3 months before pregnancy. White non-Hispanic women were reported to have smoked in the 3 months before pregnancy at over twice the rate of non-Hispanic Black women. Arkansas PRAMS 2007 report indicated 18.2% of women smoked in the last three months of pregnancy. The percent of White NH women (25.1%) were still significantly higher than the percent of Black NH women (6.1%) that reported smoking in the last three months of pregnancy. Women that returned to smoking after pregnancy reported by AR PRAMS 2007 showed 57% of women who quit during pregnancy started again after delivery.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Arkansas Tobacco Quitline provided assistance to tobacco users via phone or online. Pregnant women received a specialized program.			X	
2. The Arkansas Tobacco Quitline Pregnancy Program provided up to 10 calls with relapse prevention sensitivity during pregnancy and at least 2 postpartum contacts.			X	
3. Screening for tobacco use, tobacco prevention and education was provided at each Women's Health and WIC visit in the local health units.			X	
4. ADH Nurse Practitioners and Clinicians utilized the UAMS ANGELS tobacco dependence/cessation guidelines for pregnant, postpartum and family planning clients.			X	
5. PRAMS data were utilized to monitor and evaluate smoking data in pregnant women.				X
6. Local Health Units faxed referrals to the Arkansas Tobacco Quitline for interested mothers and mothers-to-be.		X		
7.				
8.				
9.				
10.				

b. Current Activities

ADH's goal is to expand our tobacco cessation services and achieve a goal of reaching 25,000 Arkansans annually. The Arkansas Tobacco Quitline, operated by Free & Clear, provides assistance to tobacco users via phone or online, tailored to the specific needs of each tobacco user, including smokeless tobacco. Women who are pregnant are eligible for a specialized cessation program.

Arkansas Tobacco Quitline (ATQ) takes a woman-centered approach, balancing the benefits of quitting for both the fetus and the woman. Exposure to Second-Hand Smoke (SHS) is a major health risk to the baby (asthma, ear infections, SIDS, etc.) and sustaining cessation beyond delivery is equally important to the health of the mother. While cessation during pregnancy has important and specific health relevance for the fetus, the ATQ protocol is designed to emphasize the importance of remaining tobacco-free beyond delivery. Mothers are provided at least two postpartum interventions.

Pregnant tobacco-users often have some guilt about their tobacco use and the harm it may cause their babies. Quit Coaches are supportive of and empathetic with pregnant tobacco users. In addition, Quit Coaches provide information about pharmacotherapy options specific to pregnant women. This tobacco cessation intervention seeks to encourage women to engage in meaningful discussion with their physicians about the pros and cons of using pharmacotherapy to aid their cessation effort.

c. Plan for the Coming Year

Tobacco prevention and cessation education will continue to be provided in ADH clinics. English and Spanish smoking cessation educational material is available for the clients though the ADH Tobacco Prevention and Cessation Program. The Arkansas Tobacco Quitline, operated by Free & Clear, will continue to provide assistance to tobacco users via phone or online.

The Arkansas Tobacco Quitline Pregnancy Program includes:
•Up to 10 calls with relapse prevention sensitivity. The first 5-6 calls will be completed within 60 to 90 days of enrollment.
•One call will be delivered 30 days prior to the planned due date.
•At least two postpartum contacts (15 days and 45 days postpartum)
•Structured content for pregnant smokers in contemplation quitting

The ATQ pregnancy program is for all Arkansas female residents over 18 years of age, who are planning pregnancy in the next 3 months, currently pregnant, and/or currently breastfeeding. Interested mothers and mothers-to-be can call 1-800-QUIT-NOW or 1-800-784-8669 or enroll through their local health unit by fax referral.

ADH will continue to screen patients for tobacco use, counsel and educate on the effects of tobacco, and refer clients to tobacco cessation programs. ADH will continue to provide PRAMS data to state health officials and policy-makers.

Performance Measure 16: *The rate (per 100,000) of suicide deaths among youths aged 15 through 19.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	7	4.5	10	9	8
Annual Indicator	5.6	14.2	9.7	8.1	10.6
Numerator	11	28	19	16	21
Denominator	195324	196748	196492	197560	197560
Data Source					2008 Death Certificates
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	10	8	7	7	6.5

Notes - 2008
2007 population estimate 15-19 years was used for 2008 rate.

The 2008 data are lacking deaths that occurred to Arkansas residents in other states. Interstate exchange agreements between states guarantee death certificates to Arkansas from other states, but the process may be prolonged.

In addition, death certificates may be delayed due to causes of deaths pending by County Coroners or the medical examiner.

These two circumstances above may ultimately result in a higher mortality rate than is reported for 2008.

Notes - 2007
2007 death data are provisional.

The 2007 data are lacking deaths that occurred to Arkansas residents in other states. Interstate exchange agreements between states guarantee death certificates to Arkansas from other states, but the process may be prolonged.

Notes - 2006
Used 2005 population estimate 15-19 years for 2006 indicator.

a. Last Year's Accomplishments
The Youth Suicide Prevention Task Force, established by Act 1757 of 2005, took on several projects last year. In partnership with the Jason Foundation at Pinnacle Pointe (a psychiatric hospital offering inpatient and outpatient services to children and adolescents), the Task Force sponsored a poetry and a video PSA production contest. Entries were received from students around the state, with the respective winners honored at an awards ceremony in March 2009.

Administrative support for the Task Force is housed within the Department of Education (ADE). Within the past year, staff from ADE provided training in a large number of high schools and middle schools to school personnel (teachers, counselors, school nurses) and interested members of the community on possible warning signs of pre-suicidal behavior, along with steps to take when signs are recognized. The trainings utilized the "Gatekeeper" model which originated in Maine.

During the past year, the Task Force also developed plans to distribute "pocket cards" to public school students (see below).

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Youth Suicide Prevention Task Force established by Act 1757 of 2005 continued to meet every quarter.				X
2. A mental health advisory board established to assist the Task Force also continued to be active.				X
3. Trainings for school and community personnel on warning signs of suicidal behavior and action steps were provided in schools statewide				X
4. The Task Force sponsored statewide poetry and video PSA production contests for student entrants, and awarded prizes to winners			X	
5. The Task Force completed development of pocket cards for distribution to middle school and high school students			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Youth Suicide Prevention Task Force continues to meet on a quarterly basis. The group has recently finalized creation of pocket-sized cards for distribution to public school students that contain resources for acute help, such as crisis line numbers and examples of others that youth can turn to for assistance. The Department of Education will distribute 300,000 cards through its regional cooperatives, probably at the beginning of the 2009-2010 school year.

c. Plan for the Coming Year
Original funding for the YSP Task Force is set to expire at the end of the state fiscal year. The enabling legislation had no "sunset clause," and therefore the group is planning to continue to meet, at least for the foreseeable future. However, some of their discussions will center around the future role of the Task Force in the absence of programmatic funding. One area that is expected to be considered relates to assessment of training programs targeted directly to students. In the coming year, the Task Force will likely review examples of such programs from other states, and make recommendations to the Department of Education for one or two it deems particularly worthwhile for implementation here.

Act 603 requires each school to appoint a Parent Facilitator to work directly with parents and the community. These activities will continue.

Performance Measure 17: *Percent of very low birth weight infants delivered at facilities for high-risk deliveries and neonates.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	67	67	67	69	70
Annual Indicator	63.6	66.5	66.0	58.8	64.6
Numerator	463	451	479	448	451
Denominator	728	678	726	762	698
Data Source					2008 Birth Certificates
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	70	69	68	68	67

Notes - 2008
2008 indicator represent data from Federal Fiscal year 2008.

Notes - 2007
2007 indicator represent data from Federal Fiscal year 2007.

a. Last Year's Accomplishments
The successes of the Rural Hospital Program and the growing interest among rural providers for further clinical support justified expansion of telemedicine services in Arkansas. ANGELS has not only equalized care through telemedicine, it has also increased appropriate maternal transports to the UAMS tertiary care center, while also pioneering a uniformed Medicaid billing procedure.

Further, the increase in high-risk maternal transports to UAMS has simultaneously increased the number of low birth weight infants delivered at UAMS. In 2008, ANGELS performed 1,400 telemedicine consultations; facilitated 1,058 high-risk maternal transports to the closest, most appropriate hospital; administered evidence-based medication recommendations to 72% of maternal transports that were not otherwise administering best practices to emergent, pregnant women; and accepted and made 151,097 obstetrical support calls through the 24/7 RN-staffed ANGELS Call Center.

Table 4a, National Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. UAMS ANGELS provided evidence-based guidelines for physicans throughout Arkansas.				X
2. UAMS provided telemedicine consultations, high risk maternal transports to the closest appropriate hospital and a 24/7 RN Staffed ANGELS call center.		X		
3. ADH maternity clinics were provided consultation and referral to UAMS High Risk Maternity Clinic through a UAMS Nurse Liaison.		X		
4. ADH provided 61 public health maternity clinics in 55 counties staffed by trained public health nurses, Nurse Practitioners and two physician specialists.	X			
5. ADH maternity clinics saw 4768 women for initial prenatal visits, which included providing Medicaid enrollment and referral services.		X		
6. ADH Maternity patients were routinely screened for pre-term labor risks at each visit.	X			
7. ANGELS weekly telemedicine conferences were attended by OB/GYN's and Pediatricians throughout the state.				X
8.				
9.				
10.				

b. Current Activities

The ANGELS project will continue. Current ANGELS initatives include high-risk pregnancy consultations, evidence based guidelines, 24/7 OB call center, maternal-fetal research and telemedicine. ANGELS affords 1) high-risk pregnancy consultation and education utilizing interactive, real-time Level II ultrasounds as provided by the state's only board-certified Maternal-Fetal Medicine specialists and Genetic Counselors; 2) statewide obstetrical and neonatal evidence-based guideline creation, review, and distribution among a network of rural providers in Arkansas; and 3) facilitation of appropriate high-risk maternal transports throughout the state and surrounding region.

The establishment of The Arkansas Tobacco Quitline, operated by Free & Clear, provides assistance to tobacco users via phone or online, tailored to the specific needs of each tobacco user, including smokeless tobacco. Women who are pregnant are eligible for a specialized cessation program. Arkansas Tobacco Quitline (ATQ) takes a woman-centered approach, balancing the benefits of quitting for both the fetus and the woman.

c. Plan for the Coming Year

ANGELS' success has spawned a series of related efforts to launch telemedicine services in other University specialty disciplines. ANGELS' founders and collaborators formed the UAMS Center for Distance Health in 2006, which creates a support mechanism and systematic channel

for all of the University's new telemedicine efforts. Further, this new Center directly offers telemedicine, continuing medical and health education, public health education, and evaluation research through interactive video in Arkansas.

Performance Measure 18: *Percent of infants born to pregnant women receiving prenatal care beginning in the first trimester.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	81	81	81	81	82
Annual Indicator	79.2	78.8	77.3	76.4	76.4
Numerator	30200	30827	31065	31602	31450
Denominator	38130	39101	40203	41380	41168
Data Source					2008 Birth Certificates
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	82	82	82	82	82

Notes - 2008
2008 indicator represent data from Federal Fiscal Year 2008.

Notes - 2007
2007 indicator represent data from Federal Fiscal Year 2007.

a. Last Year's Accomplishments
ADH continues to support the Healthy Baby Happy Birthday Baby Book. Healthy Baby is a program of the Arkansas Department of Health that encourages all pregnant women to receive early and continuous prenatal care. A total of 13,003 books were provided to Arkansas's pregnant women, with an additional 204 out-of-state requests. The Healthy Baby Happy Birthday Baby Book can be requested by phone, internet or prepaid postcard.

The ADH Resources and Health Information Line, established in 1991, is a statewide, confidential, toll free information system that operates Monday-Friday, 8:00am to 4:30pm. It is staffed with employees trained to provide callers with public health and referral resource information. An electronic intranet resource is available to local health units through the ADH Intranet.

The Health Connections Section, through a contract with Arkansas Medicaid, works to connect Arkansas Medicaid recipients to healthcare providers and health resources in their community. This activity is performed by helpline operators who staff a telephone toll free helpline. The helpline operators' primary function is to assign Medicaid and ARKids recipients to a primary care physician and provide dental case management. They also respond to Medicaid and ARKids recipient questions and concerns, giving information and offering guidance on accessing local health resources.

The Department of Health continues direct provision of maternity services in 61 Local Health Unit sites in 55 counties. Local Health Units continue to work with their communities and providers to ensure pregnant women have access to prenatal care. Clients are screened for presumptive eligibility Medicaid; given information on, and referrals to, medical providers; and afforded access to other ADH services. The Local Health Units saw 4768 pregnant women for their initial prenatal appointments in CY2008, of which 2610 (54%) were seen in their first trimester.

ADH continues to serve the hard-to-reach populations of pregnant women. Women with socioeconomic issues such as poverty, substance abuse or domestic violence seek the non-judgmental care of the local health unit. Local Health Units provide pregnancy testing for women who want to confirm their pregnancy or those seeking pregnancy. During CY2008, 14,203 pregnancy tests were performed and prenatal or preconception counseling as per ADH policies was provided at the clinic visit.

The Perinatal Health Program oversees the Lay Midwife (LMW) Program. Currently, there are 30 Licensed Lay Midwives and 14 Lay Midwife Apprentices. The choice to use a lay midwife for home birth may provide a viable alternative to maternity care in Arkansas, particularly for low risk pregnant women. LHU's provide risk assessments and referrals, as needed, for the LMW clients.

The Perinatal Program, ADH Women's Health Section, provided a Fall Maternity Training Program to ADH Nurses. This continuing education opportunity is designed for Public Health Nurses, Maternal Infant Program Nurses, and LPN's who are new to maternity services. This training is also offered as a continuing education for Lay Midwives. Nurses learn to take histories, identify high risk factors, educate and counsel pregnant women, and identify referral services in a four day training. Experts in their fields present topics on pregnancy, smoking, infections, domestic violence, nutrition and more.

ADH continued to support and participate in the UAMS ANGELS activities, incorporating their guidelines into ADH policies. Activities include co-management of prenatal patients with UAMS Maternal Fetal Medicine (MFM), patient referrals to ANGELS, Telemedicine referrals, and prenatal genetic screening.

Table 4a, National Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. ADH provided 61 public health maternity clinics in 55 counties staffed by trained public health nurses, Nurse Practitioners with two physician specialists. Prenatal services were provided by ADH for a record maintenance fee of $5.00 per visit or free	X			
2. ADH maternity clinics saw 4768 women for initial prenatal visits, including Medicaid enrollment and referral services.		X		
3. The Healthy Baby Happy Birthday Baby Book, which encourages early prenatal care and pregnancy information, was provided free to pregnant women when requested by phone or on-line.		X		
4. The Healthy Baby Happy Birthday Baby Book included coupons that were validated according to the prenatal visit, encouraging early and consistent prenatal care.		X		
5. PRAMS data were used for program planning and dissemination of information and data to the public and private entities.				X

6. The ADH MCH Epidemiologist provided data on program needs and analysis of common perinatal indicators.				X
7. ADH continued to participate in and support UAMS ANGELS activities, incorporating their guidelines into ADH policies.				X
8.				
9.				
10.				

b. Current Activities

ADH will continue to provide and support maternity clinics in the local health units. Referrals to private providers will be facilitated by continuing to provide the application process for presumptive eligibility in local health units in each ADH Region.

ADH continues to support and provide staff for the Happy Birthday Baby Book, a coupon book designed as an incentive for pregnant women to obtain and continue prenatal care.

ADH clinicians and public health nurses continue to utilize the UAMS High-Risk OB-GYN Nurse Liaison in referrals for high risk conditions of pregnancy. The UAMS Nurse Liaison facilitates telephone consultations and appointment scheduling as needed for LHU maternity patients.

The ADH Chief Physician Specialist continues to utilize ANGELS and the ANGELS Guidelines in the policies and care of ADH maternity patients. ADH physicians continue to participate in the ANGELS teleconferences and provide direction regarding ADH policies.

The PRAMS Grant is used extensively for program planning and dissemination of information and data to public and private entities throughout Arkansas. ADH continues to support the MCH Epidemiologist position. This individual provides continued work on program evaluation, needs assessment and analysis of common perinatal health indicators.

c. Plan for the Coming Year

ADH will continue to provide support for the local health units' maternity clinics, as well as for collaborative activities surrounding the UAMS ANGELS program. New nursing staff will be provided training by the ADH Maternity Training Program. ADH will continue to support the MCH Epidemiologist position. Support will continue for the Happy Birthday Baby Book. ADH physicians will continue to participate in the ANGELS teleconferences and provide direction regarding ADH policies. The Family Health Branch will continue utilization of the perinatal information obtained through PRAMS.

D. State Performance Measures

State Performance Measure 1: *The percent of Arkansas high school students who have engaged in sexual intercourse.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective			55	55	55
Annual Indicator	51.9	54	54	54.9	54.9
Numerator					
Denominator					
Data Source					YRBSS
Is the Data Provisional or Final?				Final	Final

	2009	2010	2011	2012	2013
Annual Performance Objective	54	53	52	51	50

Notes - 2008
Data source: 2007 YRBSS.
YRBSS is conducted in odd years. The 2007 survey results are reported for the 2008 indicator.

Notes - 2007
Data source is 2007 national Youth Risk Behavior Survey.

Notes - 2006
YRBSS is conducted in odd years. The 2005 survey results are reported for the 2006 indicator.

Arkansas has conducted many (10 this past year) community-based Abstinence Education projects. As many as 14 have been funded in past years. A behavioral-science evaluation of considerable scientific expertise (in our view) is showing that in these projects, students do respond to educational messages. Using a before-after self report methodology covering many thousands of students, those "exposed" to the educational "dose" report more favorable sexual values, beliefs, intentions, and behaviors at one year after the beginning of their educational "dose." However, when followed to 12 months after cessation of the "dose," their self-reported values, beliefs, intentions, and behaviors return to the levels of their "non-exposed" peers. This information was shared in a verbal report to the DOH (now ADH) leadership. A final report is awaited, and due in September 2007.

a. Last Year's Accomplishments
The Abstinence Education Program funded 10 community projects, (schools, faith, and community-based organizations) throughout the state, targeting youth ages 12 to 29 years, during the last federal fiscal 2007 and 2008 years. During federal fiscal years 2003-2007, the sub-grantees participated in a health-behavioral research evaluation. The evaluator, Institute for Research and Evaluation, for 5 years, provided regular reports on the overall evaluation and by project. Technical assistance was provided to all active sub-grantees during those years. An Interim Report received May 2007 revealed that positive improvements among students receiving abstinence education were noted during the time the abstinence education activities were received. However, twelve months after the close of the intervention, the students' reported knowledge, attitudes, and behavioral intentions were not measurably different from comparison peers. Improvement in students' attitudes and intentions toward sexual activity reverted back to where they were before they started the program.

During State Fiscal Year 2008, the ADH utilized State General Revenue along with federal funds to help support abstinence education program activities. In May 2007, the State was notified that federal funding was ending June 30, 2007. Later, the program was authorized through September 30, 2007 and then federal funding was extended until December 30, 2008. Similarly in 2008, the state received notification that the federal program was extended until June 30, 2008. This pattern provided short time periods to award the funds to the 10 sub-grantees and often gaps in federal funding.

ADH and the Unwed Birth Comprehensive Strategies Committee funded a limited number of Unwed Birth Prevention Program sub-recipient agreements with County Coalitions since 1998 through a competitive process by submitting a request for application. The purpose of providing funds to local communities in targeted Arkansas Counties to stimulate or support coalitions to develop/implement locally designed programs to reduce unwed teenage pregnancy. Targeted counties are chosen from those with the highest teen pregnancy rates in the state with the goals to reduce teen pregnancy among adolescents through implementation of at least one "Program that Work" curricula. The "Programs That Work" are eight different curricula for which exists the strongest evidence of effectiveness in reducing the sexual risk-taking behavior of teens when the curricula are implemented with fidelity. There were 8 counties with Unwed Birth Prevention

Grantees and one technical assistance grantee during SFY2008.

During SFY 2008 (most recent data available July 1, 2007 -- June 30, 2008) the Unwed Birth Prevention Program served the following number of youth: 5,832 (on-going activities)+3,632 (one-time basis)=9,464 (total impacted). On-going programs are those that engage youth more than once during the program year, and are broken down into two types: "Programs That Work," and "Other Ongoing Programs." One-time programs are those that engage youth only once during the program year, and are broken down into two types: "Family Planning Services" and "Other One-Time Programs."

Since the 1995 Arkansas Youth Risk Behavior Survey (YRBS), the percentage of students who had ever had sexual intercourse has decreased from 61.5 (1995) to 54.9 (2007). The percentage of students who had sexual intercourse for the first time has shown a decrease from 13.7(1995) to 9.3(2007). Both are considered linear changes in behavior.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. The Abstinence Education Program funded 10 community projects targeting youth aged 12 to 29		X		
2. The Abstinence Education Program reviewed results of an independent evaluation of the program				X
3. The Unwed Birth Prevention Program funded 4 county coalitions with state funds to develop pregnancy prevention and education activities.		X		
4. Youth Risk Behavior Studies were conducted in 3 counties in 2008.				X
5. ADH Local Health units each provided at least two family planning outreach activities.		X		
6. The ADH Home Town Health Initiative's activities included family planning outreach to teens and hard to reach populations.		X		
7. The Center for Local Public Health began implementing a system that will send family planning appointment reminders to clients that are past due for their annual exam.		X		
8. Title X offered free or reduced family planning services in 91 local health units across the state.			X	
9. ADH MCH Epidemiologist provided statistical program data and analysis of common indicators to be used in program planning.				X
10.				

b. Current Activities

Currently, there are 6 sub-grants for the AEP. In August 2008, the State submitted an application for the Title V Abstinence Education Grant Program for FY 2009-2013. In December 2008, the State received notification of award only through June 30, 2009, three months short of the federal grant year. For State FY2009, the ADH has continued to use State General Revenue to assist in supporting the AEP in Arkansas.

The IRE submitted the Phase V Final Report November 2008. The Phase V Final Report focused on initiation and discontinuation rates for sexual activity and further analysis of the maintenance/deterioration effect on the short term measures for the combined dataset that included 2005-2006 and 2006-2007 data. Program males initiated sex at a significantly lower rate than comparison students. Strong conclusions regarding program effects over time can not be

made, as any observed changes could merely reflect differences between the samples from year to year.

The Agency is requesting funding to provide for the continuation of the Unwed Birth Prevention sub grants. ADH, Women's Health, provides funding and technical assistance to support the Home Town Health Initiatives (HHI) for family planning outreach. Title X funds also support the family planning activities of Ouachita Children's Center and Wilbur D. Mills Substance Abuse Program. ADH Family Planning efforts have included an outreach flyer to be used to reach a population unaware of their family planning services.

c. Plan for the Coming Year

For the current 6 AEP sub-grantees, monitoring and tracking along with process evaluation and data collection are continuing. Based on the two-year data analysis and evaluation by IRE and current research, the AEP will emphasize to current and future sub-grantees to provide 14 or more hours of abstinence education to the target population, encourage that sub-grantees offer multiple opportunities for youth to attend abstinence education activities, and request sub-grantees that are not serving middle school youth to submit a plan for continuing service or implementing follow-up for youth beyond the middle school years. The ADH plans to utilize the Epidemiology Section to assist with the evaluation, in particular tracking and monitoring sub-grantees to determine if 14 hours or more of direct abstinence education are provided to clients served.

Plans are for the Family Planning Program to continue to expand efforts at outreach to teenagers through the local health units in each county. Women's Health will work with the Center for Local Public Health to facilitate family planning appointment reminders for all family planning clients needing their annual exams. ADH will work with the Unwed Birth Prevention sub grantees, as well as the Title X sub grantees at Ouachita Children's Center and Wilbur Mills Substance Abuse Program in their efforts to reach teens and other high risk populations. ADH continues to monitor and evaluate the Family Planning Program per Title X requirements.

State Performance Measure 2: *The percentage of children through age 18 and below 200 percent of poverty enrolled in ARKids First child health insurance program.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	18	18	85	35	35
Annual Indicator	83.3	85.6	91.2	76.4	76.9
Numerator	290170	290170	295053	305720	301038
Denominator	348257	339000	323408	400372	391490
Data Source					Arkansas Medicaid Program
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	79	82	82	82	82

Notes - 2008

Population below 200 percent of poverty data source: US Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2008. 2008 population below 200 percent of poverty are from 2007.

ARKids First Enrollment data source: DHS Medicaid Program. This is an unduplicated count.

Notes - 2007
2007 population below 200 percent of poverty are from 2006.
Population below 200 percent of poverty data source: US Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2007.

ARKids First Enrollment data source: DHS Medicaid Program. This is an unduplicated count.

Notes - 2006
2006 population below 200 percent of poverty are from 2005.
Population below 200 percent of poverty data source: US Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2006.

ARKids First Enrollment data source: DHS Medicaid Program. This is an unduplicated count.

As of 7-15-07, we are still trying to confirm this information. It is not consistent either with earlier data, nor with evidence that AR Kids First continues to serve more children in Arkansas.

a. Last Year's Accomplishments

Health Connections Section (HCS) Health Educator staff, funded through the Medicaid ConnectCare contract, provided Health Education/Promotion/Outreach, working collaboratively with schools, Head Starts, Hometown Health, local health units and other local organizations. In an effort to encourage enrollment, particular emphasis was placed in areas of the State with a high Medicaid-eligible population. The Health Educator staff continued establishing their role as a resource to support school-based Human Service Workers. Partnering with Coordinated School Health, the second annual fall Human Service worker workshop was held. The workshop provided information on available resources, types of support/assistance available to Medicaid recipients, Medicaid application process, preventive health information, and opportunities for networking and coordination. The Health Educator staff produced a variety of newsletters brochures, and other written materials addressing such concerns as prenatal care, WIC, immunizations, newborn screening, tobacco use and obesity.

The Arkansas Finish Line Coalition, composed of a large number of health, social service, and education organizations, conducted a campaign to promote a variety of measures related to health coverage for children. These included expansion of Medicaid to more children, creation of electronic enrollment and re-enrollment systems, continuous coverage for children served under traditional Medicaid (ARKids A), and creation of a buy-in option for families just over the income limit. The Coalition, which was staffed by Arkansas Advocates for Children and Families, received broad attention and support for its efforts.

A tax on tobacco products passed in the 2009 General Assembly (Act 180) included a provision for expansion of Medicaid benefits to children up to 250% of poverty. This expansion is expected to have secondary effects of increased enrollment among children who would have already been eligible under the current eligibility limit (200% FPL).

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. Health Connections Section staff provided promotion and outreach involving schools, Head Starts, Hometown Health, local health units and other groups to encourage Medicaid enrollment.		X		
2. Health Connections staff served as resources for school-		X		

based Human Service Workers involved in Medicaid recruitment activities.				
3. Health Connections collaborated with Coordinated School Health to present a workshop for Human Service Workers.				X
4. The Arkansas Finish Line Coalition supported a number of related measures such as continuous enrollment, presumptive enrollment, and development of electronic enrollment systems.				X
5. Act 180 was passed providing for expanded Medicaid eligibility, which should also promote enrollment among those already eligible.				X
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Finish Line Coalition continues to pursue its goals of presumptive enrollment for children who appear to be eligible, as well as electronic enrollment and re-enrollment systems development. Discussions between the state Medicaid program and key stakeholders around these subjects are ongoing, and are expected to lead to programmatic changes that further facilitate and maintain enrollment among eligibles.

HCS activities outline above continue this year. HCS is intensifying health education/promotion/outreach efforts to schools and Human Service Workers based in schools with a high Medicaid eligible population by identifying local resources and facilitating resource coordination. HCS is developing its contract with Medicaid to establish more positions for ConnectCare to link Medicaid recipients to primary care physicians.

c. Plan for the Coming Year

ADH will continue to partner with the state Medicaid agency, Arkansas Advocates for Children and Families, and all the other Finish Line organizations to move toward shared goals of enhanced enrollment for eligible children.

The Health Connections Section will continue those activities listed under "current year activities" above.

HCS will build relationships with WIC, immunizations, tobacco, and dental health to assure that during contact to set up a PCP assignment, that contact is used to provide other key health care information related to prenatal care, smoking cessation, dental care, well child care and other preventive health issues.

State Performance Measure 3: *The percent of pregnant women counseled for HIV testing.*

Tracking Performance Measures

[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	75	75	0	0	68
Annual Indicator	64.5	67.4	67.4	67.0	66.7
Numerator	22704	23760	23760	24604	24458
Denominator	35212	35276	35276	36724	36649
Data Source					Arkansas

					PRAMS
Is the Data Provisional or Final?				Final	Final
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	69	70	71	72	73

Notes - 2008
Data source: 2008 data are from the 2007 PRAMS survey.

Notes - 2007
2007 data source is 2006 PRAMS survey.

Notes - 2006
Data source: 2005 Arkansas PRAMS survey.
2006 cells populated with 2005 PRAMS numbers.

Breast feeding awareness and counselling efforts are now administratively co-located with WIC, and managed by that Branch. Their statewide efforts continue. There has been a steady upward trend in breastfeeding in Arkansas, so we would expect the next PRAMS survey carrying these questions to reveal no decrease.

a. Last Year's Accomplishments
ADH provided maternity services in 61 Local Health unit sites in 55 counties. Local Health Units, including staff and HHI Coalitions, continue to work within their communities and providers to ensure pregnant women access to prenatal care. Clients are screened for presumptive eligibility Medicaid and ineligible aliens/non-citizens are screened under the State Children's Health Insurance Program for Pregnant Women. These pregnant women are provided referral information to providers and have access to other ADH services. The Local Health Units saw 4269 pregnant women for initial prenatal appointments in CY 2008. ADH continues to serve the hard-to-reach populations of pregnant women. Women with socioeconomic issues such as poverty, substance abuse, or domestic violence seek the non-judgmental care of the local health unit. Prenatal patients must be provided counseling to determine any risk factors for HIV (Pre-test counseling) even if they opt out of the test. Post-test counseling is also provided. Clients with risk factors are rescreened during their pregnancy, if applicable.
ADH clinical policies include a maternity education class for its prenatal patients on sexually transmitted infections.
ADH Business Objects report that 4064 HIV (serum and rapid oral swab HIV tests) tests were performed at initial maternity visits. An additional 1044 HIV tests were performed at subsequent and other maternity visits, which would be duplicated clients. UAMS continues to be the referral source for women testing positive for HIV during pregnancy.

Family Planning clients are routinely offered HIV counseling and testing, which facilitates identification of this risk factor in women prior to pregnancy and during the postpartum period. ADH Business Objects reported that 13,898 family planning annual clients received HIV testing in CY 2008. HIV testing is provided in all Local Health Units, even those not providing Women's Health services such as Maternity and Family Planning.

The HIV/STD Section continues to provide outreach education and HIV testing throughout the state. Business Objects reported in CY 2008 the ADH HIV/STD program tested clients (duplicated, men and women).
UAMS ANGELS continued to receive the referrals for women testing positive for HIV.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**

1. ADH maternity patients were screened for HIV at their initial appointment and if risks for HIV were identified at subsequent prenatal or postpartum visits.			X	
2. ADH followed CDC guidelines for HIV testing and provided pre and post HIV test counseling and education.		X		
3. ADH local health units provided HIV testing for family planning, STD and other women's health patients, facilitating identification of patients with HIV before they planned a pregnancy or became pregnant.	X			
4. Arkansas State Law requires pregnant women be tested for HIV. (Patients may decline the test.)				X
5. ADH AIDS/HIV Section continued to provide outreach education and HIV testing throughout the state.			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

The Department of Health provides prenatal care which includes physical assessments, laboratory testing, genetic screening and counseling, prenatal education, nutritional counseling and education, WIC services, and referral as indicated for high risk care. The ADH provides prenatal care in 55 counties and 61 local public health units. All ADH staff who provide HIV counseling testing services must attend the HIV Counseling course provided by ADH. HIV antibody counseling and testing is routinely performed in ADH local health unit clinics where services are provided to men and women. Counseling and testing services are strongly encouraged for persons with HIV exposure risks or risk behaviors. For clients receiving rapid HIV tests, HIV Prevention Counseling Risk Reduction Plan is initiated and updated with each visit related to the rapid test

c. Plan for the Coming Year

ADH will continue to provide direct patient care services. Voluntary, confidential HIV counseling and testing will continue to be provided by ADH. HIV testing has been expanded to include rapid HIV tests for clients with HIV exposure risk factors. ADH staff will attend the HIV course to provide effective prevention counseling and risk reduction plans for patients. Arkansas has an "OPT Out" legal requirement that pregnant women be tested for syphilis, Hepatitis B, and HIV, or that refusal by the patient be documented in writing. ADH will continue to counsel and instruct pregnant women about HIV and prevention for the unborn infant.

ADH Women's Health programs will continue to participate in the activities and work of the HIV/STD Program.

State Performance Measure 4: *Percentage of children receiving WIC services who are above the 95th percentile on the National Center for Health Statistic weight for height growth charts.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	6	5	5	5	11.5
Annual Indicator	10.8	10.7	11.2	11.2	13.9

Numerator	8060	7876	8781	9553	5364
Denominator	74630	73610	78402	85295	38591
Data Source					Arkansas WIC - PEDNSS (CDC)
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	13	12	11	10	9.7

Notes - 2008
The majority of children receiving WIC services are preschool age children.
Data are from the PEDNSS report provided by CDC.

Notes - 2007
Data are from the PEDNSS report provided by CDC.

Notes - 2006
Data are from the PEDNSS report provided by CDC.

The increase in percentage of WIC kids over 95th percentile is noted. This is across all WIC ages, but that group is heavily concentrated with kids at or below school age.

Arkansas has been working intensively on an obesity prevention project carried out in all schools in the state, now both public and private. The state is measuring BMI with usable reports on over 300,000 school children per year, mostly from kindergarden to 12th grades, with larger school districts reporting on pre-K also. Having tracked these children for the third year, we are seeing no increase in the percentage of children in the overweight and at-risk-for-overweight categories. In fact a slight decline was evident in comparing the last two years' data.

We believe, looking at YRBS data over several decades, that there is a great deal of "momentum" toward a continuing rise in percentages of overweight and at-risk children. So any leveling of this trend seems hopeful.

As Arkansas's school-based obesity awareness campaign informs families of their children's health, it is at least theoretically possible that this education will result in improvements in diet and activity for yourngger children in these families. The National Performance Measure related to WIC children 2-5 looks at this in a more refined way.

a. Last Year's Accomplishments
As in the past, children participating in WIC were prescribed food packages based upon age, but tailored to fit individual needs. All participants received nutrition education designed to address immediate concerns and improve overall health. In addition, one-on-one nutrition counseling with a registered dietician regarding specific nutrition-related health problems continued to be available in local health units.

WIC also carried out the Farmers' Market Nutrition Program, the mission of which is to encourage the consumption of fresh fruits and vegetables, and encourage development of farmers' markets. Women and children residing in counties with farmers' markets were eligible to receive food coupons which could be redeemed for fresh produce.

The WIC Program implemented a new MIS -- Successful Partners in Reaching Innovative Technology (SPIRIT). This project was funded by the USDA Food and Nutrition Service. SPIRIT is a State Agency Model (SAM) designed to reduce paperwork, improve program integrity and security, improve data accuracy, state efficiency and productivity and reduce system support and maintenance issues.

The Program also successfully implemented the Value Enhanced Nutrition Assessment (VENA). VENA takes a positive approach based on desired health outcomes rather than deficiencies. VENA's emphasis is to improve the current assessment practices by promoting a positive, client-centered approach to obtain information that is used to:

-determine nutrition eligibility
-provide individualized nutrition education
-tailor food package
-make appropriate referrals

WIC began making plans to implement the Interim Food Package rule, which will provide fruits and vegetables (fresh and frozen), whole grains (bread, tortillas, brown rice), and soy beverages. The rule must be implemented by October, 2009.

Training provided to WIC field and state office staff included Rapport Building and Communication Skills-Critical Thinking.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. The WIC program successfully implemented the Value Enhanced Nutrition Assessment.			X	
2. The WIC program implemented a new management information information system (SPIRIT).				X
3. WIC trained state and local staff in rapport-building and communication skills/critical thinking.				X
4. WIC participants received food packages tailored to age and individual needs.		X		
5. WIC conducted the Farmers' Market Nutrition Program, which provided fresh produce to participants in selected counties.		X		
6. WIC participants received general nutrition education, and one-on-one nutritional counseling as needed for specific health issues.		X		
7.				
8.				
9.				
10.				

b. Current Activities

WIC continues the activities described above.

Local health unit staff training related to the implementation of the Interim Food Package Rule is progressing. "WIC Food Packages: Making the Change Work" is an interactive approach to assisting WIC Competent Professional Authorities (CPAs) in assessing participants to prescribe appropriate food packages and nutrition education. In addition, clerical staff will receive training regarding their role.

Implementation and training on the new management information system continues.

c. Plan for the Coming Year

1. Continuation of current activities as described.

2. Assessment and drafting of new policy for the new WIC food package. The Interim Food Package Rule was released by USDA in December of 2007 with mandatory implementation by October 1, 2009. Arkansas is participating in several work groups to determine issues that must be addressed such as gathering product information from food manufacturers; determining systems changes; anticipating steps to implement.

State Performance Measure 5: *To improve the percent of 14 to 15 year olds on Children's Medical Services (CMS) who state that CMS transition services have helped improve their knowledge and ability to transition into adult life.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	7	8	9	10	22
Annual Indicator	7.9	7.9	5.5	21.7	21.7
Numerator	3	3	10	15	15
Denominator	38	38	182	69	69
Data Source					Data is from 2008 AR CSHCN program survey
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	23	24	25	26	26

Notes - 2008
This information was taken from a survey completed in 2008 which specifically asked about CMS transition services. Our Transition Survey mailed in the month of the YSHCN 14th birthday does not ask the specific question; however, does ask if there is contact with the CMS Care Coordinator. 27 of 94 respondants in the past year indicated 'Yes' to this question.

Notes - 2007
This data was supplied from responses on our statewide survey done in early 2008 on Transition and program assistance provided by the states' Title V CSHCN staff.

Notes - 2006
There was no Parent Satisfaction survey sent this year.
This data was supplied with information collected on the 2006 CSHCN Transition Survey.

a. Last Year's Accomplishments
The program continued mail-out of a transition-focused survey to YSHCN in our database in the month of their 14th birthday. Survey responses generated contact between caseworkers and families on transition issues. CSHCN staff provided transition information by displaying at Transition Fairs and other meetings. Training was provided to all CSHCN staff over two days on transition issues such as education opportunities, economic assistance, job training opportunities and health care transition.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Transition surveys were received from 116 youth with responses that assisted our staff in planning services for the				X

YSHCN.				
2. Staff participated in AR Interagency Transition Partnership with Dept of Education, Higher Education, Disability Rights, Rehabilitation Services and DHS agencies serving adolescents and young adults (DDS CFS, Behavioral Health and Youth Services).				X
3. Staff worked with individual YSHCN and other local program representatives to develop individual transition plans.		X		
4. CSHCN staff worked with local councils to staff Transition Fairs at Dept. of Education's regional Education Cooperatives. The fairs were attended by youth throughout several school districts who are served through Special Education and 504.		X		
5.				
6.				
7.				
8.				
9.				
10.				

b. Current Activities
The Transition survey is mailed to all individuals on the CSHCN database in the month of their 14th birthday. Surveys indicating that assistance is needed are forwarded to CSHCN staff for individual contact. CSHCN staff assist families of YSHCN in completion of DDS Alternative Community Services Home and Community Based Waiver applications and Aging and Adult Services Waivers for the Physically Disabled.

Regional Managers monitor service plans to assess information and assistance provided on Transition topics.

c. Plan for the Coming Year
Develop newsletter article/series on Transition. Continue the Transition Survey. Target transition issues during Needs Assessment process.

State Performance Measure 6: *Improve percent of parents responding to the question on Children's Medical Services (CMS) Parent Satisfaction Survey that CMS service coordination teams told them about other services available.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	57	61	63	65	52
Annual Indicator	51.9	51.9	51.9	55.7	55.7
Numerator	28	28	28	151	151
Denominator	54	54	54	271	271
Data Source					Data from AR CSHCN program survey
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	56	57	58	58	58

Notes - 2008

This data is taken from a family survey in early 2008.

Notes - 2007
This data was compiled from responses to our statewide surveys sent out in early 2008.

Notes - 2006
A Parent Satisfaction survey was not sent out this year; however, anecdotal evidence (audit review of casework and programs, telephone contact with families by management staff, etc) indicates that the data collected in the 2004survey has not changed substantially.

a. Last Year's Accomplishments
All CSHCN caseworkers have been relieved of the Part C Early Intervention job responsibilities and have devoted their time and energy to CSHCN casework activities. These include Title V CSHCN Family Support/Respite program activities, application for DDS programs (DDS Waiver, Special Needs, & Integrated Supports), disability categories of Medicaid (SSI and TEFRA), nutrition resources (community food pantries, WIC and Food Stamps) and interagency programs such as CASSP. All applications are evaluated at the time of initial application to determine if eligible services are being accessed. Referrals are made for medical care at AR Children's Hospital, one of ACH's regional specialty clinics, or local providers. Referrals are also made for specialized services such as construction of wheelchair ramps and purchase of equipment not paid for by Medicaid (ceiling lifts and van lifts).

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. Provided assistance in application for short-term emergency assistance from private and public programs.		X		
2. Provided referral and assistance in applying for long-term wrap-around services such as the DDS Waiver.		X		
3. Provided referral and assistance in applying for short-term wrap-around services.		X		
4. Upon request from the parent/guardian, staff assisted with referral and application for residential treatment services.		X		
5. Provided assistance in accessing funding via Title V CSHCN program for equipment or services not covered by Medicaid.	X			
6. Worked in conjunction with other programs (public and private) to provide resources and assistance to families of dually diagnosed children in crisis.		X		
7. Provided referral for Part C Early Intervention services.		X		
8. Staff made appropriate referrals for Medicaid based on the family financial status and the level of disability of the CSHCN.		X		
9.				
10.				

b. Current Activities
CSHCN staff serve as a referral source for access to Title V program benefits (Title V Family Support/Respite and purchase of services not covered by Medicaid as funding allows) and DDS programs (DDS Waiver, Special Needs, Integrated Supports and ICF/MR program).

c. Plan for the Coming Year
There will be continued referral for services within and outside the Division. No foreseeable changes to be made.

State Performance Measure 7: *The percent of public school students overweight greater than 95th percentile.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	11	9	7	5	20.4
Annual Indicator	21.0	20.8	20.5	20.6	20.5
Numerator	72636	77351	75596	75544	36599
Denominator	345892	371367	369416	366801	178181
Data Source					Arkansas Center for Health Improvement
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	20.2	20	19.8	19.6	19.4

Notes - 2008
Source: Arkansas Center for Health Improvement: Assessment of Childhood and Adolescent Obesity in Arkansas, Year Five (Fall 2007 - Spring 2008).

The change in the numerator and denominator is a result of a legislative change in assessment periodicity established by Act 201 of 2007 to only include students in even-number grades (K, 2, 4, 6, 8, and 10).

Notes - 2007
Source: Arkansas Center for Health Improvement: Assessment of Childhood and Adolescent Obesity in Arkansas, Year Four (Fall 2006 - Spring 2007).

Beginning in 2007, BMI measurements are done for every other grade - even grades from Kindergarten through grade 10. Some schools with pre-K programs are assessing these children as well.

The 2006 notes are in error regarding tracking of the same students year to year. Rather percentages are based on individual grades each year.

Notes - 2006
Source: Arkansas Center for Health Improvement: The Arkansas Assessment of Childhood and Adolescent Obesity - Tracking Progress: Online Report 3 (Fall 2005 - Spring 2006).

These data show a level, or slightly declining, trend in the percentage of students who are overweight. That finding occurs in a major statewide study measuring BMI in as many as 371,000 students. This number represents a strong majority of the approximately 400,000 K-12 students in Arkansas. The BMI measurements are taken in schools, and communicated to parents confidentially in a letter. The measurement has been done for each student each year (where we are able), so Arkansas can track individual students from one year to the next. The stable or sightly declining trend in the percentages of both overweight and at-risk-for-overweight children is measured in the same students from one year to the next. That these percentages are not increasing, and perhaps even showing a slight decline, is a very important finding.

That these studies were done in schools and on all kids (as many as possible) has made this effort a major community-based project about which there has been a great deal of publicity and

dialogue. The project is being assessed by a research evaluation conducted by the College of Public Health at UAMS. So far, surveys of parents has returned little complaint about how their child's information was handled. So far the results regarding behaviors of students and families regarding nutrition and physical activity has shown less clear impact, but these changes on self-report may take more time to reveal.

a. Last Year's Accomplishments

In late 2008, the UAMS College of Public Health completed its assessment of the fifth year of activities as a result of Act 1220 of 2003, which mandated BMI measurements and a number of other anti-obesity efforts in Arkansas public schools. The report shows that school district policies related to physical education and physical activity continue to improve, especially for elementary schools. For these students, an increasing number of schools prohibit use of physical activity as a punishment, require lifetime physical activities as part of PE programs, and require certification of newly hired PE teachers. As for nutrition, more schools overall prohibit "junk foods" from being offered in cafeteria lines, at student parties, in school stores, and in vending machines. Students report significantly less access to food and beverage machines, with significantly fewer purchases from these machines per month. Finally, since 2003 schools have nearly eliminated students' access to vending machines prior to and during lunch periods.

In 2008, plans were made to update the data entry system for BMI measurements obtained in schools. This system is a web-based program operated through the Arkansas Center for Health Improvement, which allows automatic calculation of BMI's when weight and height data are entered. ADH Community Health Promotion Specialists (CHPS's) and Community Health Nurse Specialists (CHNS's) trained school personnel on use of the updated system in January and February of 2009. The Arkansas Center for Health Improvement continued to compile and analyze BMI measurements obtained by public schools in accordance with Act 1220.

The Arkansas Department of Education received initial funding for the Fresh Fruit and Vegetable Program in the 2008-09 school year. Goals of the program are to create healthier school environments by providing healthier food choices, to increase children's consumption of fruits and vegetables, and to expand the variety of fruits and vegetables to which children are exposed. Children receive free fresh fruits and vegetables throughout the school day, along with nutrition education. The program also encourages community partnerships. During the 2008-09 school year, 30 elementary schools with 11,532 students participated. Participating schools were selected following an RFP process.

Coordinated School Health sites were also involved in anti-obesity activities. During the past school year, 28 CSH school districts undertook a variety of efforts; for example, partnerships with Boys and Girls Clubs to utilize individual wellness plans, revival of intramural sports, implementation of "play-before-eat" policies, and development of several creative walking programs. Quarterly trainings related to available fitness and nutrition resources were delivered to these schools by various presenters.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. In response to Act 1220 requirements, schools increasingly restricted access to vending machines, particularly just before or during lunch periods.				X
2. Elementary schools increasingly implemented policies favorable to physical activity and physical education.				X
3. School districts maintained Wellness Committees in accordance with Act 1220.				X
4. Public school students in even-numbered grades K-10 had BMI measurements performed, with results sent in a confidential			X	

manner to their parents with recommendations for follow-up with a physician, as needed.				
5. ADH Community Health Nurse Specialists trained school personnel on use of new web-based software for entering BMI data.				X
6. The Fresh Fruit and Vegetable Program received initial funding in Arkansas, providing 30 elementary schools and 11,532 students with a variety of free fruits and vegetables along with nutrition education.			X	
7. Coordinated School Health sites took on a number of anti-obesity initiatives (e.g intramural sports, play-before-eat policies, and walking programs).			X	
8.				
9.				
10.				

b. Current Activities

The Child Health Advisory Committee, also created under Act 1220, continues to consider and recommend policies and programs to the Departments of Education and Health relative to fitness and nutrition. The group, composed of a multidisciplinary group of health, nutrition, and education professionals from public and private sectors, meets quarterly.

BMI measurements continue to be obtained in public schools, although as noted the frequency of measurements was reduced in 2007. Students are now measured in even grades, K-10.

The Child Nutrition Unit at ADE is currently reviewing proposals from schools for the Fresh Fruit and Vegetable Program for the 2009-2010 school year.

Twenty- three CSH schools continue to focus on health and academic achievement for the whole child using the Coordinated School Health (CSH) model. This is the first year CSH is recognizing a district with a "Healthy School Board Award." This honor will be anounced at the school health summit during the summer, in recognition of a school board that has demonstrated proactive efforts in creating a healthy environment in its schools. School districts in contention for this award have implemented policies such as water-only vending, extended breakfasts, play-before-eat, and no fast food on campus.

c. Plan for the Coming Year

School districts will continue to consider new policies which reduce students' access to unhealthy foods, and improve opportunities for physical activity within the school environment. The Child Health Advisory Committee is developing a large set of recommendations for schools, health-related entities, and policymakers based on eight "Guiding Principles." It is anticipated that these will be finalized and widely distributed within the coming year.

BMI measurements will continue in schools as per legislative mandate. Other aspects of Act 1220 will continue to be monitored and evaluated by the UAMS College of Public Health under a grant from the Robert Wood Johnson Foundation.

The Fresh Fruit and Vegetable Program will have just over $1 million of funding available to schools for the 2009-2010 school year. The Child Nutrition Unit at ADE anticipates funding a larger number of schools in the coming year (perhaps 45-50). As stated previously, interested schools have already submitted proposals.

Coordinated School Health is sponsoring two programs, "Fitnessgram" and "Spark," in 3 pilot school districts next year, with benefits related to improved fitness to be assessed. CSH has also partnered with Arkansas Children's Hospital to purchase HealthTeacher.com for all CSH schools

to utilize to improve health literacy.

State Performance Measure 8: *The percentage of at-risk for overweight children in Arkansas public schools.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective	11	9	7	5	17.1
Annual Indicator	17.2	17.2	17.1	17.2	17.4
Numerator	59503	63943	63315	63059	30917
Denominator	345892	372369	369416	366801	178181
Data Source					Arkansas Center for Health Improvement
Is the Data Provisional or Final?				Final	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	17	16.8	16.7	16.6	16.5

Notes - 2008
Source: Arkansas Center for Health Improvement: Assessment of Childhood and Adolescent Obesity in Arkansas, Year Five (Fall 2007 - Spring 2008).

The change in the numerator and denominator is a result of a legislative change in assessment periodicity established by Act 201 of 2007 to only include students in even-number grades (K, 2, 4, 6, 8, and 10).

Notes - 2007
Source: Arkansas Center for Health Improvement: Assessment of Childhood and Adolescent Obesity in Arkansas, Year Four (Fall 2006 - Spring 2007).

Notes - 2006
Source: Arkansas Center for Health Improvement, Fall 2005 - Spring 2006.

This level, or slightly declining trend regarding at-risk for overweight children in schools is noted. Please see comments in field notes for the mesurements of the overweight group.

a. Last Year's Accomplishments
In late 2008, the UAMS College of Public Health completed its assessment of the fifth year of activities as a result of Act 1220 of 2003, which mandated BMI measurements and a number of other anti-obesity efforts in Arkansas public schools. The report shows that school district policies related to physical education and physical activity continue to improve, especially for elementary schools. For these students, an increasing number of schools prohibit use of physical activity as a punishment, require lifetime physical activities as part of PE programs, and require certification of newly hired PE teachers. As for nutrition, more schools overall prohibit "junk foods" from being offered in cafeteria lines, at student parties, in school stores, and in vending machines. Students report significantly less access to food and beverage machines, with significantly fewer purchases from these machines per month. Finally, since 2003 schools have nearly eliminated students' access to vending machines prior to and during lunch periods.

In 2008, plans were made to update the data entry system for BMI measurements obtained in schools. This system is a web-based program operated through the Arkansas Center for Health Improvement, which allows automatic calculation of BMI's when weight and height data are entered. ADH Community Health Promotion Specialists (CHPS's) and Community Health Nurse Specialists (CHNS's) trained school personnel on use of the updated system in January and February of 2009. The Arkansas Center for Health Improvement continued to compile and analyze BMI measurements obtained by public schools in accordance with Act 1220.

The Arkansas Department of Education received initial funding for the Fresh Fruit and Vegetable Program in the 2008-09 school year. Goals of the program are to create healthier school environments by providing healthier food choices, to increase children's consumption of fruits and vegetables, and to expand the variety of fruits and vegetables to which children are exposed. Children receive free fresh fruits and vegetables throughout the school day, along with nutrition education. The program also encourages community partnerships. During the 2008-09 school year, 30 elementary schools with 11,532 students participated. Participating schools were selected following an RFP process.

Coordinated School Health sites were also involved in anti-obesity activities. During the past school year, 28 CSH school districts undertook a variety of efforts; for example, partnerships with Boys and Girls Clubs to utilize individual wellness plans, revival of intramural sports, implementation of "play-before-eat" policies, and development of several creative walking programs. Quarterly trainings related to available fitness and nutrition resources were delivered to these schools by various presenters.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**
1. In response to Act 1220 requirements, schools increasingly restricted access to vending machines, particularly just before or during lunch periods.				X
2. Elementary schools increasingly implemented policies favorable to physical activity and physical education.				X
3. School districts maintained Wellness Committees in accordance with Act 1220.				X
4. Public school students in even-numbered grades K-10 had BMI measurements performed, with results sent in a confidential manner to their parents with recommendations for follow-up with a physician, as needed.			X	
5. ADH Community Health Nurse Specialists trained school personnel on use of new web-based software for entering BMI data.				X
6. The Fresh Fruit and Vegetable Program received initial funding in Arkansas, providing 30 elementary schools and 11,532 students with a variety of free fruits and vegetables along with nutrition education.			X	
7. Coordinated School Health sites took on a number of anti-obesity initiatives (e.g intramural sports, play-before-eat policies, and walking programs).			X	
8.				
9.				
10.				

b. Current Activities

The Child Health Advisory Committee, also created under Act 1220, continues to consider and recommend policies and programs to the Departments of Education and Health relative to fitness and nutrition. The group, composed of a multidisciplinary group of health, nutrition, and education professionals from public and private sectors, meets quarterly.

BMI measurements continue to be obtained in public schools, although as noted the frequency of measurements was reduced in 2007. Students are now measured in even grades, K-10.

The Child Nutrition Unit at ADE is currently reviewing proposals from schools for the Fresh Fruit and Vegetable Program for the 2009-2010 school year.

Twenty- three CSH schools continue to focus on health and academic achievement for the whole child using the Coordinated School Health (CSH) model. This is the first year CSH is recognizing a district with a "Healthy School Board Award." This honor will be anounced at the school health summit during the summer, in recognition of a school board that has demonstrated proactive efforts in creating a healthy environment in its schools. School districts in contention for this award have implemented policies such as water-only vending, extended breakfasts, play-before-eat, and no fast food on campus.

c. Plan for the Coming Year

School districts will continue to consider new policies which reduce students' access to unhealthy foods, and improve opportunities for physical activity within the school environment. The Child Health Advisory Committee is developing a large set of recommendations for schools, health-related entities, and policymakers based on eight "Guiding Principles." It is anticipated that these will be finalized and widely distributed within the coming year.

BMI measurements will continue in schools as per legislative mandate. Other aspects of Act 1220 will continue to be monitored and evaluated by the UAMS College of Public Health under a grant from the Robert Wood Johnson Foundation.

The Fresh Fruit and Vegetable Program will have just over $1 million of funding available to schools for the 2009-2010 school year. The Child Nutrition Unit at ADE anticipates funding a larger number of schools in the coming year (perhaps 45-50). As stated previously, interested schools have already submitted proposals.

Coordinated School Health is sponsoring two programs, "Fitnessgram" and "Spark," in 3 pilot school districts next year, with benefits related to improved fitness to be assessed. CSH has also partnered with Arkansas Children's Hospital to purchase HealthTeacher.com for all CSH schools to utilize to improve health literacy.

State Performance Measure 9: *The percent of women smoking during pregnancy.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	2004	2005	2006	2007	2008
Annual Performance Objective	15	13	11	11	15
Annual Indicator	20.3	16.2	15.9	15.7	15.3
Numerator	7069	6370	6530	6504	6188
Denominator	34825	39210	40966	41341	40489
Data Source					Birth Certificates

Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	14.8	14.4	14	13.5	13.4

Notes - 2008
Source: 2008 Birth Certificate Data, Health Statistics Branch, Arkansas Department of Health

Notes - 2007
Source: 2007 Birth Certificate Data, Health Statistics Branch, Arkansas Department of Health

Notes - 2006
Source: Health Statistics - 2006 Birth Certificates

While smoking data on birth certificates may be somewhat under-reported, the under-reporting seems pretty consistent across states, demographic groups, and years. This apparent small decline is consistent with the ANGELS program's developing services to help pregnant women quit. The ANGELS hotline provides community-based resource information to women who call in with this question. In addition, ANGELS has included in its clinical guidelines, and therefore underscores the issue with providers, the importance of quitting. Additionally, ANGELS is developing a questionnaire to be used in prenatal clinics and at preconceptional health visits to help more accurately assess for smoking behaviors. So far, ADH is awaiting the completed validation of the questionnaire before using them more widely in our prenatal and family planning clinics.

a. Last Year's Accomplishments
Beginning October 1, 2008, the Arkansas Tobacco Quitline began operating through Free & Clear, Inc. The Stamp Out Smoking telephone line and fax back referral was in place Jan-Sept. 2008. As one of the nation's leading tobacco cessation treatment providers, Free & Clear's Quit for Life Program will help ADH expand our cessation services. Two toll free numbers and a fax referral program will be offered. Women who are pregnant are eligible for a specialized cessation program with additional benefits.

All maternity, family planning, WIC and STD clients seen in the ADH's local health units are screened for tobacco use. This is a required question in the history and counseling components of the Women's Health and WIC programs. Women's Health Programs include up-to-date smoking cessation policies as guidelines for the Public Health Nurse, ADH Nurse Practitioners and Clinicians utilize the UAMS ANGELS tobacco dependence/cessation guidelines for pregnant, postpartum and family planning clients. Programs provide written information in English or Spanish on the risks of smoking and information on resources for cessation. ADH encounter management system (Business Objects) reported smoking cessation education on 1261 encounters for maternity clients. Clients receive education on the effects of tobacco/smoking in pregnancy and the identification of this as a preconception risk.

PRAMS provides data for Arkansas state health officials to use to improve the health of mothers and infants. Provisional 2007 PRAMS data shows 31.2% of Arkansas women smoked in the 3 months before pregnancy. White non-Hispanic women were reported to have smoked in the 3 months before pregnancy at over twice the rate of non-Hispanic Black women. The Arkansas PRAMS 2007 report indicates 18.2% of women smoked in the last three months of pregnancy. The percentage of White NH women (25.1%) who reported smoking in the last three months of pregnancy was still significantly higher than the percentage of Black NH women (6.1%). Unfortunately, 57% of women returned to smoking after quitting during pregnancy.

Table 4b, State Performance Measures Summary Sheet

Activities	**Pyramid Level of Service**			
	DHC	**ES**	**PBS**	**IB**

1. The Arkansas Tobacco Quitline provided assistance to tobacco users via phone or on-line, with a Pregnancy Program with relapse prevention.			X	
2. The AR Tobacco Quitline Pregnancy Program provided 10 calls with relapse prevention during the pregnancy and at least 2 postpartum calls.			X	
3. ADH local health units faxed referrals to the Arkansas Tobacco Quitline for interested mothers or mothers-to-be.		X		
4. ADH maternity, family planning and WIC clinics screened clients for tobacco use and offered assistance, education and referral to the AR Tobacco Quitline.			X	
5. ADH Nurse Practitioners utilized the UAMS ANGELS tobacco dependence/cessation evidence-based guidelines for pregnant, postpartum and family planning clients.				X
6. PRAMS data were utilized to monitor and evaluate data on pregnant women who smoke.				X
7.				
8.				
9.				
10.				

b. Current Activities

Arkansas Tobacco Quitline (ATQ) takes a woman-centered approach, balancing the benefits of quitting for both the fetus and the woman. While cessation during pregnancy has important and specific health relevance for the fetus, the ATQ protocol is designed to emphasize the importance of remaining quit beyond delivery. Mothers are provided at least two postpartum interventions.

Quit Coaches are supportive of and empathetic with pregnant tobacco-users. Quit Coaches provide information about pharmacotherapy options specific to pregnant women. This tobacco cessation intervention seeks to educate women to engage in meaningful discussion with their physicians about the pros and cons of using pharmacotherapy to aid their cessation effort.

The Arkansas Tobacco Quitline Pregnancy Program includes up to 10 calls with relapse prevention sensitivity. The ATQ pregnancy program is for all Arkansas female residents over 18 years of age, who are planning pregnancy in the next 3 months, currently pregnant, and/or currently breastfeeding. Since the ATQ launch in October 2008, more than 300 female tobacco-users who were planning pregnancy, currently pregnant, or currently breastfeeding have called to enroll or receive information about quitline services. Of these callers, more than 100 have enrolled in the ATQ Pregnancy Program. Interested mothers and mothers-to-be can call 1-800-QUIT-NOW or 1-800-784-8669 or enroll through their local health unit by fax referral.

c. Plan for the Coming Year

The Arkansas Tobacco Quitline, operated by Free & Clear, will continue to provide assistance to tobacco users via phone or online. ADH's goal is to expand our tobacco cessation services and achieve a goal of reaching 25,000 Arkansans annually. The Arkansas Tobacco Quitline, operated by Free & Clear, provides assistance to tobacco users via phone or online, tailored to the specific needs of each tobacco user, including smokeless tobacco. Women who are pregnant are eligible for a specialized cessation program. Tobacco prevention and cessation education will continue to be provided in ADH clinics. English and Spanish smoking cessation educational materials are available for the clients though the ADH Tobacco Prevention and Cessation Program. ADH will continue to screen patients for tobacco use, counsel and educate on the effects of tobacco, and refer clients to tobacco cessation programs. ADH will continue to utilize PRAMS to provide data for Arkansas state health officials and policy-makers.

State Performance Measure 10: *To increase the percentage of ADH Family Planning clients receiving nutritional counseling during an initial or annual visit in the Family Planning clinics.*

Tracking Performance Measures
[Secs 485 (2)(2)(B)(iii) and 486 (a)(2)(A)(iii)]

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Performance Objective			0	80	86
Annual Indicator	61.5	73.7	75.6	84.0	83.9
Numerator	31784	36537	35779	38439	39398
Denominator	51704	49582	47341	45770	46968
Data Source					ADH: Business Objects
Is the Data Provisional or Final?				Provisional	Provisional
	2009	**2010**	**2011**	**2012**	**2013**
Annual Performance Objective	87	88	89	90	91

Notes - 2008
Source is Business Objects: family planning encounters that reported Nutritional Counseling-non WIC and 34 Nutrition assessments.

Notes - 2007
Source is Business Objects: family planning encounters that reported Nutritional Counseling-non WIC and 34 Nutrition assessments.

Notes - 2006
The Performance Measure was changed to reflect data that we are presently able to collect. Plans for the future are to advocate for the collection of data in the Information Management System for BMI, counseling on BMI and if the patient was overweight.

Numerator and denominator are from the Information Management System.

The Family Health Branch is now working toward a strategic planning dialogue with "sister" Branches in the Center for Health Advancement to consider the issue of preconceptional counseling. We are broadening this concept to include pre- and inter-conceptional counseling in a broader-based program of Women's Health counseling. Arkansas's Healthy Arkansas Campaign has already produced solid gains in computer-based risk assessment and physical exercise challenges conducted in the Department of Health as an employer, in Blue-Cross/Blue Shield as an employer, and now an additional 60 or so other firms throughout the state. We have therefore, already begun an effort to find women in the workplace. By adding the details of a preconceptional or interconceptional health risk appraisal to the general health appraisal already conducted regarding nutrition and physical activity, it seems plausible that a broader Women's Health Counseling campaign could be developed in Arkansas. The next opportunity for widening the approach to women of reproductive age, may lie in collaborative efforts with schools, chronic disease programs, smoking cessation programs, and WIC, not to mention Maternity and Family Planning Clinics across the state.

a. Last Year's Accomplishments
In Business Objects (CY 2008), a total of 70,621 Family Planning encounters reported Nutrition Counseling Non-WIC and 13 reported Nutrition Assessments. A total of 39,398 reported Nutrition Counseling Non-WIC at the Family Planning Annual exam. Women and men in the Family Planning clinics are screened for weight, height and Body Mass Index (BMI) calculations at the Annual Exam and as needed for Subsequent Visits. Written educational pamphlets are offered in English and Spanish in addition to individual counseling by the Local Health Unit Nurses and Clinicians. Family Planning services are offered in 86 Local Health Units.

Table 4b, State Performance Measures Summary Sheet

Activities	Pyramid Level of Service			
	DHC	ES	PBS	IB
1. ADH Family Planning clients were screened and informed of their BMI at their annual exam.			X	
2. In addition to BMI data, ADH Local Health units provided nutritional education/counseling and emphasis on healthy lifestyles to family planning clients.		X		
3. ADH Encounters reported 55% of all annual family planning clients received Nutritional counseling in addition to required BMI information.		X		
4. Community Nurse Specialists partnered with schools and school nurses to address health related issues in Arkansas public schools, including obesity and nutrition.			X	
5. The Healthy Arkansas Website provided strategies to reduce obesity, physical inactivity and tobacco cessation.			X	
6.				
7.				
8.				
9.				
10.				

b. Current Activities

ADH Local Health Units continue to provide BMI assessment, Nutrition Education/Counseling and emphasis on healthy lifestyles. Preconception identification of BMI>30 provides an opportunity to further educate the client on this Prenatal risk. ADH employees are encouraged to utilize the Arkansas Healthy Employees Lifestyle (AHELP) and Blue and You Fitness Challenge. AHELP is a comprehensive effort to clearly define specific areas where behavioral changes can lead to healthier lifestyle. The Healthy Arkansas website provides strategies to reduce and/or eliminate tobacco use, obesity and physical inactivity with information on nutrition, physical activity and smoking cessation. ADH employees were offered the opportunity to continue activities that promote a healthy lifestyle by participating in the 8 weeks WOMAN Challenge sponsored by the National Office on Women's Health. These activities facilitate the health of ADH employees, and therefore set a good example for the clients, families and citizens we serve in our Local Health Units. Home Town Health has actively participated in workgroups and key events targeting obesity prevention, nutrition and physical activity in communities throughout Arkansas. Community Health Nurse Specialists have developed CD's for BMI training, provided information on fitness challenges and health fairs, and partnered with schools and school nurses to address health-related issues in Arkansas's public schools.

c. Plan for the Coming Year

Efforts to identify resources for referral for nutritional counseling will continue. ADH will continue to look for ways to develop partnerships to stimulate plans and activities to reduce obesity and its risks. Community Health Nurse Specialists will continue efforts in the public schools to address health related issues such as nutrition, physical activities and tobacco. Local Home Town Health Improvement coalitions will continue to work with communities to address obesity, chronic disease and health disparities.

E. Health Status Indicators

Introduction

/2010/ Health status indicators provide additional exploration of certain problems only touched upon in performance measures, such as childhood injury and premature births. The indicators also provide in-depth analysis of key demographic variables, such as breakdowns by age and race/ethnicity, or by residence in urban vs. rural areas. These analyses are very useful for planning purposes, helping to direct resources to groups most in need as well as to groups for whom successful intervention will lead to more favorable outcomes for the state as a whole. When studied over time, the indicators afford one a sense of shifting demographic trends within the state. Through examination of total population numbers, these analyses help remind the program that the goal is to improve every person's health, not just those served directly by program activities.

Indicators that include rates over a five-year period are particularly useful in helping monitor trends of various conditions and problems. When major initiatives have been introduced to address a given problem, such rates can also be useful in helping establish whether the intervention was effective (although other concurrent activities, events, and mitigating circumstances in the state must also be factored in before drawing sweeping conclusions). //2010//

Health Status Indicators 01A: *The percent of live births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	9.3	9.1	9.1	9.5	9.2
Numerator	3562	3546	3667	3945	3788
Denominator	38130	39101	40203	41380	41168
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008

Data source: 2008 birth certificate data for fiscal year 2008 - October 1, 2007 through September 30, 2008.

Notes - 2007

Data source: 2007 birth certificate data for fiscal year 2007 - October 1, 2006 through September 30, 2007.

The sharp increase in low birth weight rate for Arkansas is clearly noted. We are studying this phenomenon. It appears that the largest increases have occurred among the higher birth weight portion of this group - 2000 to 2500 grams. This is also reflected in increases in the percentage of all births that occur late preterm - 34-37 weeks. These findings need assessment in detail. Some questions we are looking into: are we inducing labor or performing c-sections too early?

Narrative:

/2010/ The low birth weight rate for Arkansas seems to have peaked in 2007, but that can only be confirmed if final and subsequent rates continue downward. This rate is notoriously difficult to impact upon, as there is little evidence of an effective preventive intervention for community level action. Arkansas continues to believe that the healthy young woman has a better chance to have a healthy pregnancy and therefore a healthy infant. This philosophy leads to the further development of health counseling for young women and men, as promulgated by those interested in preconception/interconception health programs. It is known that just under 40% of pregnant women who experience a perinatal death have a recognized prepregnancy health risk factor. Arkansas continues to pursue a focus on reducing infant mortality that exercises preconception counseling approaches. The rise in LBW rates has been associated with increases in cesarean sections and inductions, with a "shading off" of percentages of births with prenatal care beginning in the first trimester, and with economic events leading to the current downturn. We are especially chagrinned by the widening African American disparities in many of these indicators in Arkansas. New discussions about racism are leading to new understandings about the experience of African American mothers with the health care system. //2010//

Health Status Indicators 01B: *The percent of live singleton births weighing less than 2,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	7.6	7.4	7.5	7.8	7.4
Numerator	2797	2811	2907	3109	2951
Denominator	36934	37914	38971	40063	39858
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008

Data source: 2008 birth certificate data for fiscal year 2008 - October 1, 2007 through September 30, 2008.

Notes - 2007

Data source: 2007 birth certificate data for fiscal year 2007 - October 1, 2006 through September 30, 2007.

It is clear that the phenomenon of increases in low weight births can not be explained by multiples and assisted reproductive therapy alone. We also notice an increase in late preterm births. Please see comments under the total low birth weight rate measure.

Notes - 2006

The LBW rate for singletons appears to have peaked in 2004, dropped in 2005, and remained steady in 2006, for the total population.

Narrative:

/2010/ It has been clear for a while that increasing low birth weight rates are not confined to increasing proportions of multiple births, though that contributes also. A few general explanations are discussed above. //2010//

Health Status Indicators 02A: *The percent of live births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	1.9	1.7	1.8	1.8	1.7
Numerator	728	678	726	762	698
Denominator	38130	39101	40203	41380	41168
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
Data source: 2008 birth certificate data for fiscal year 2008 - October 1, 2007 through September 30, 2008.

Notes - 2007
Data source: 2007 birth certificate data for fiscal year 2007 - October 1, 2006 through September 30, 2007.

The increase in births below 1500 grams is also noted and is of great concern. We need to look also at the percentage of births at a gestational age of 32 weeks to see if that parallels the birth weight trend. These analyses will be made carefully over the next few months to clarify our developing needs.

Notes - 2006
The Arkansas VLBW rate appears to have peaked in 2004, but is tending to remain high at 1.8% in 2006.

Narrative:
/2010/ See discussion under LBW rates for births under 2500 grams. //2010//

Health Status Indicators 02B: *The percent of live singleton births weighing less than 1,500 grams.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	1.5	1.4	1.4	1.4	1.3
Numerator	551	520	563	573	537
Denominator	36934	37914	38971	40063	39858
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the					

last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
Data source: 2008 birth certificate data for fiscal year 2008 - October 1, 2007 through September 30, 2008.

Notes - 2007
The trend for very low birth weight among singleton births seems pretty flat. Thus it seems that our increases in low birth weight rates are impacted more by moderately LBW infants and late preterm births. We are investigating this finding.

Narrative:
/2010/ See discussion for singleton births under 2500 grams. //2010//

Health Status Indicators 03A: *The death rate per 100,000 due to unintentional injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	15.4	16.5	13.2	11.4	10.4
Numerator	86	92	75	66	60
Denominator	560107	557472	569943	579442	579442
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
2007 population estimate 0 - 14 years used for 2008 rate

The 2008 data are lacking deaths that occurred to Arkansas residents in other states. Interstate exchange agreements between states guarantee death certificates to Arkansas from other states, but the process may be prolonged.

In addition, death certificates may be delayed due to causes of deaths pending by County Coroners or the medical examiner.

These two circumstances above may ultimately result in a higher mortality rate than is reported for 2008.

If, however, this rate is accurate, then the apparent decline in death rates in the past two years to children under 14 is gratifying. Certainly a great deal more public emphasis at community level has been brought to bear through programmatic efforts around seat belt use and fire burn prevention. We need to assess future numbers to see if this dramatic drop holds up. It may be a "bounce," and not reflect a true trend.

Notes - 2007

The 2007 data are lacking deaths that occurred to Arkansas residents in other states. Interstate exchange agreements between states guarantee death certificates to Arkansas from other states, but the process may be prolonged.

In addition, death certificates may be delayed due to causes of deaths pending by County Coroners or the medical examiner.

These two circumstances above may ultimately result in a higher mortality rate than is reported for 2007.

If, however, this rate is accurate, then the apparent decline in death rates to children under 14 is gratifying. Certainly a great deal more public emphasis at community level has been brought to bear through programmatic efforts around seat belt use and fire burn prevention. We need to assess future numbers to see if this dramatic drop holds up. It may be a one-year "bounce."

Notes - 2006
2005 population estimate 0 - 14 years used for 2006 indicator.

The decline in death rate for children 14 and under, reflected here, seems significant. Motor vehicle crashes as a cause of deaths to children this age explain most of the unintentional injury deaths. Public efforts to increase awareness of and use of seatbelts have been strong.

Narrative:
/2010/ Unintentional injury deaths from all causes showed a definite decline in Arkansas during 2006. The rates for 2007 and 2008 are still provisional, but the final rates will probably be no higher than in 2006. Arkansas has traditionally borne an excess of childhood injury deaths, often at rates up to twice the national rate. The Injury Prevention & Control Branch has partnered with a number of groups to improve the situation, including the Safe Kids Coalition, the Injury Prevention Program housed at ACH and operated through the UAMS Department of Pediatrics, firefighter associations, law enforcement, the State Highway and Transportation Department, Hometown Health Improvement teams, and others. Target injuries have included burns (especially from house fires), motor vehicle crash injuries, and drownings.

Several key pieces of legislation were passed during the 2009 Arkansas General Assembly that should further decrease unintentional injury deaths among children. One of these, Act 180, provides funds to create a comprehensive trauma system within the state. Arkansas is one of the last states to implement such a system, which will improve on-scene management of trauma victims and facilitate transport to an appropriately equipped medical facility. Another new act provides for primary enforcement of the seat belt law, which should reduce motor vehicle crash deaths by at least 15% overall. //2010//

Health Status Indicators 03B: *The death rate per 100,000 for unintentional injuries among children aged 14 years and younger due to motor vehicle crashes.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	8.4	5.7	7.5	5.7	4.0
Numerator	47	32	43	33	23
Denominator	560107	557472	569943	579442	579442
Check this box if you cannot report the numerator because					

1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
2007 population estimate 0 - 14 years used for 2008 rate.

The 2008 data are lacking deaths that occurred to Arkansas residents in other states. Interstate exchange agreements between states guarantee death certificates to Arkansas from other states, but the process may be prolonged.

In addition, death certificates may be delayed due to causes of deaths pending by County Coroners or the medical examiner.

These two circumstances above may ultimately result in a higher mortality rate than is reported for 2008.

However, if this rate is accurate, the fact that this trend is showing a sharp drop in deaths due to motor vehicle crashes goes along with new public emphasis on seat belt use, and among new awareness of all terrain vehicle dangers. This pattern goes along with programmatic efforts.

Notes - 2007
The 2007 data are lacking deaths that occurred to Arkansas residents in other states. Interstate exchange agreements between states guarantee death certificates to Arkansas from other states, but the process may be prolonged.

In addition, death certificates may be delayed due to causes of deaths pending by County Coroners or the medical examiner.

These two circumstances above may ultimately result in a higher mortality rate than is reported for 2007.

However, if this rate is accurate, the fact that this trend is showing a sharp drop in deaths due to motor vehicle crashes goes along with new public emphasis on seat belt use, and among new awareness of all terrain vehicle dangers. This pattern goes along with programmatic efforts.

Notes - 2006
2005 population estimate 0 - 14 years used for 2006 indicator

While the number of childhood deaths due to motor vehicles stood at 32 in 2005 (a good drop) and remained at 34 in 2006, these numbers alone do not explain the significant drop in deaths due to all injuries to kids of this age.

Narrative:
/2010/ The rates for this indicator have clearly fluctuated over the past few years, and with 2007 and 2008 rates still provisional, no firm conclusion can be drawn regarding any possible decreases. If final rates for these years do indicate improvement in crash-associated deaths, much credit must go to the Injury Prevention program operated out of Arkansas Children's Hospital/UAMS Department of Pediatrics. Dr. Mary Aitken and her team there have have relentlessly assessed available data, causes, and solutions, and have implemented a number of strategies to target these injuries.

New laws passed in the 2009 General Assembly should also favorably impact this indicator, including a primary enforcement seat belt law, graduated driver's licensing, and further restrictions on 14 year old drivers licensed as "hardship" cases. In addition, establishment of a trauma system under recent legislation will benefit crash victims of all ages. //2010//

Health Status Indicators 03C: *The death rate per 100,000 from unintentional injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	49.7	44.8	49.2	46.8	36.6
Numerator	197	178	191	180	141
Denominator	396261	397584	388023	384967	384967
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
2007 population estimate 0 - 14 years used for 2008 rate.

The 2008 data are lacking deaths that occurred to Arkansas residents in other states. Interstate exchange agreements between states guarantee death certificates to Arkansas from other states, but the process may be prolonged.

In addition, death certificates may be delayed due to causes of deaths pending by County Coroners or the medical examiner.

These two circumstances above may ultimately result in a higher mortality rate than is reported for 2008.

However, if this rate is accurate and although we need to update our denominator data, the numbers of death to youth 15-24 seem to be sharply down, again showing agreement with the experience of children under 15. Population-wide public awareness messages could well impact both age groups.

Notes - 2007
The 2007 data are lacking deaths that occurred to Arkansas residents in other states. Interstate exchange agreements between states guarantee death certificates to Arkansas from other states, but the process may be prolonged.

In addition, death certificates may be delayed due to causes of deaths pending by County Coroners or the medical examiner.

These two circumstances above may ultimately result in a higher mortality rate than is reported for 2007.

However, if this rate is accurate, the numbers of death to youth 15-24 seem to be sharply down,

again showing agreement with the experience of children under 15. Population-wide public awareness messages could well impact both age groups.

Notes - 2006
2005 population estimate 15 - 24 years used for 2006 indicator.

Like their younger counterparts, youth 15-24 are showing a decline in death rate due to MVC. Again, the Click-it or Ticket campaign may be having an impact in Arkansas. We have still not been able to move our seatbelt law so that not wearing a belt is a primary offense.

Narrative:
/2010/ Older adolescents and young adults pose an especially high risk group for motor vehicle crash-related fatality, as evidenced by the extreme difference between the above rates and those for the 0-14 age group. Since rates for 2004-06 were up and down, and 2007 and 2008 rates remain provisional, no clear trend over the past five years is evident. As stated for HSI 03A, many groups in Arkansas are committed to reducing the excessive burden of injuries in the state. Recent legislation should also have a beneficial effect, including laws to establish a statewide trauma system, to make non-use of seat belts a primary offense, and to implement graduated licensing for drivers 16-18 years old. Although of lesser known efficacy, other laws recently enacted in Arkansas include a ban on use of cell phones while driving for those under 18, and a ban on text messaging for all drivers. //2010//

Health Status Indicators 04A: *The rate per 100,000 of all nonfatal injuries among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	347.6	367.4	372.8	366.7	352.1
Numerator	1947	2048	2125	2125	2040
Denominator	560107	557472	569943	579442	579442
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
Data source: 2007 Hospital Discharge Data System and 2007 population estimates less than 14 years.

2007 is latest available.

Notes - 2007
Data source: 2006 Hospital Discharge Data System and 2006 population estimates less than 14 years.

2006 is latest available. We will make no other comment on this trend.

Notes - 2006
2005 population estimate 0 - 14 years used for 2006 indicator.

Non-fatal injuries to children 0-14 have been increasing have been increasing at a consistent pace in Arkansas since 2002. However injury data on children, and on youth due to MVC seems consistently even or down. We need to look for other sources of injury besides motor vehicle crashes, as our public preventive efforts to use seatbelts seem to be bearing fruit.

Narrative:
/2010/ Rates of nonfatal serious injury to children remain high in Arkansas. The 2007 hospitalization rate for such injuries was well over twice the comparable national rate. More primary prevention activities are needed to avert such injuries in children. Since public policy change is in general most effective, ADH is exploring potential opportunities for additional evidence-based laws and regulations that protect children from harm. //2010//

Health Status Indicators 04B: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among children aged 14 years and younger.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	61.6	61.7	57.9	57.0	55.7
Numerator	348	344	330	330	323
Denominator	565176	557472	569943	579442	579442
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
Data source: 2007 Hospital Discharge Data System and 2007 population estimates less than 14 years.

2007 data are the latest available.

Notes - 2007
Data source: 2006 Hospital Discharge Data System and 2006 population estimates less than 14 years.

2006 data are the latest available.

We will withhold comment until later data become available.

Notes - 2006
2005 population estimate 0 - 14 years used for 2006 indicator.

Narrative:

/2010/ Rates for nonfatal motor vehicle crash-related injuries have shown a significant decrease over the past five years in Arkansas, but remain at least 50% above the comparable national rate for 0-14 year olds. Rural roads, night-time driving, younger drivers, and driver distraction all increase the risk of injury-associated crashes. Off-road vehicles such as ATV's are also used by a large segment of Arkansas youth, including those considered by many experts to be too young to safely operate such vehicles. The Injury Prevention Program operated through Arkansas Children's Hospital has made ATV injuries a special focus for prevention (see also discussion under HSI 03B). Recently enacted laws such as the primary seat belt enforcement act and new restrictions on younger drivers ("hardship" license rules, graduated licensing, bans on cell phone use) should improve injury rates for this age group. //2010//

Health Status Indicators 04C: *The rate per 100,000 of nonfatal injuries due to motor vehicle crashes among youth aged 15 through 24 years.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	160.8	155.7	156.4	157.7	153.3
Numerator	637	619	607	607	590
Denominator	396261	397584	388023	384967	384967
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Provisional	Provisional

Notes - 2008
Data source: 2007 Hospital Discharge Data System and 2007 population estimates 15-24 years.

2007 are the latest available.

Notes - 2007
Data source: 2006 Hospital Discharge Data System and 2006 population estimates 15-24 years.

2006 are the latest available.

Notes - 2006
2005 population estimate 15 - 24 years used for 2006 indicator.

Non-fatal injuries due to motor vehicle crashed seem to have peaked in 2004, and are coming down. Two programatic efforts could explain this: 1) the Click-it or Ticket Campaign, and 2) recent research and public awareness in Arkansas about injuries to youth in all-terrain vehicle accidents.

Narrative:
/2010/ The rate for nonfatal crash injuries in this age group has dropped only slightly over the past five years, but any progress is welcome. This particularly hard-to-reach age group is more vulnerable to injury and other adverse health outcomes due to (developmentally-related) risk-taking behaviors. Once again, recently enacted laws

(primary seat belt, graduated licensing, restrictions on cell phone use and text messaging while driving) should accelerate improvement in injury rates. //2010//

Health Status Indicators 05A: *The rate per 1,000 women aged 15 through 19 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	27.9	31.0	30.2	34.3	46.5
Numerator	2642	2961	2879	3299	4471
Denominator	94784	95546	95410	96115	96115
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
2007 population estimate of female population 15-19 years used for 2008 indicator.

Notes - 2007
2006 population estimate of female population 15-19 years used for 2007 indicator.

Even though the population denominator has not been updated, our concern for the steady rise in chlamydia positivity among tested young women is of very great concern. At the moment we lack a clearly proven methodology to address this trend. We will bring new emphasis to treating partners by sending medications home with the women who have positive tests. So far, we have not seen results on a special project in Washington DC in which an Internet page was used to enhance public awareness and offered a way to send in specimens for testing.

While ADH is now using the more sensitive method of urine specimen testing to test for Chlamydia, this should not fully explain the observed increase in the rate among young women in Arkansas.

Notes - 2006
2005 population estimate 15-19 years used for 2006 indicator.

Chlamydia rates among the young are still high. Arkansas's staff resources to do effective contact tracing for all positive cases remains very much unequal to that task. However, little national attention appears to be provided to this issue. One research project in Washington DC, presented at last year's AMCHP conference, is addressing this issue through the Internet. The website offers health care advice to those that come to the site, and also offers a mailed kit to collect a urine specimen for testing. The results of that study might be very interesting, if it has been completed and published.

Narrative:
/2010/ As is the case nationally, Chlamydia infection rates in Arkansas have risen in recent years. The above rate for 15-19 old females jumped (provisionally) over 35% in 2008. While part of the apparent increase may be due to improved detection methods (urinary screening using DNA amplification technology), much of the change probably reflects a true rise in incidence. Previous national studies have estimated that nearly half of all

cases occur in the 15-19 year old age group, most likely related to inherent risk-taking behaviors during adolescence. In Arkansas in 2008, 15.3% of 15-19 year old females tested were positive for Chlamydia. Perhaps even more alarming, 11.9% of tests on 10-14 year old females were positive for Chlamydia.

Routine screening and treatment of asymptomatic, sexually active females has been shown to result in reduction in Chlamydia infection rates. ADH follows American College of Obstetrics and Gynecology and CDC guidelines for routine screening for Chlamydia in family planning patients. Maternity patients cared for by ADH receive Chlamydia screening at least once during pregnancy, and most also receive a second screening due to presence of risk factors. The Department's STD Clinics test for Chlamydia among all symptomatic patients, those identified as being contacts of a known case, and those for whom history indicates a risk of exposure. In 2008, ADH detected about three times as many females with Chlamydia through family planning and maternity clinics as compared to the number detected through ADH STD clinics. This phenomenon relates to the greater amount of testing through the former programs, as well as to the often asymptomatic nature of the infection in females.

Continued adherence to national guidelines will be critical in controlling the spread of genital Chlamydia infections. However, expanded screening and treatment, as resources allow, must also be considered in light of the recently observed increase in frequency. //2010//

Health Status Indicators 05B: *The rate per 1,000 women aged 20 through 44 years with a reported case of chlamydia.*

Health Status Indicators Forms for HSI 01 through 05 - Multi-Year Data

Annual Objective and Performance Data	**2004**	**2005**	**2006**	**2007**	**2008**
Annual Indicator	7.2	7.6	7.4	9.3	12.5
Numerator	3404	3596	3502	4385	5873
Denominator	469598	471518	471606	469950	469950
Check this box if you cannot report the numerator because 1.There are fewer than 5 events over the last year, and 2.The average number of events over the last 3 years is fewer than 5 and therefore a 3-year moving average cannot be applied.					
Is the Data Provisional or Final?				Final	Provisional

Notes - 2008
2007 population estimate of female population 20-44 years used for 2008 indicator.

Notes - 2007
2006 population estimate of female population 20-44 years used for 2007 indicator.

Like younger women, those over 20 are also showing remarkable increases in chamydia positivity. We are doing more urine testing, which may be more sensitive, but should not fully explain the observed increase in the rate among women in Arkansas.

Notes - 2006
2005 population estimate 20-44 years used for 2006 indicator.

Chlamydia rates among women 20-44 years are showing high levels, but they hide a sharper

increase among women 20-24. That rate continues to climb in Arkansas. We need new measures to address this problem. See comments for Chlamydia rates for young women 15-19.

Narrative:
/2010/ Similar to the increase seen among adolescent females, the Chlamydia infection rate for 20-44 year old women jumped about 34% in 2008. This increase mirrors recent national trends. While part of the increase may be due to improved detection methods (urinary screening using DNA amplification technology), much of the change probably reflects a true rise in incidence. About a third of all Chlamydia cases are believed to occur among 20-24 year old women. In Arkansas in 2008, 7.8% of women 20 years and older tested for Chlamydia had positive results.

Routine screening and treatment of asymptomatic, sexually active females has been shown to result in reduction in Chlamydia infection rates. ADH follows American College of Obstetrics and Gynecology and CDC guidelines for routine screening for Chlamydia in family planning patients. Maternity patients cared for by ADH receive Chlamydia screening at least once during pregnancy, with a repeat in late pregnancy if risk factors exist. The Department's STD Clinics test for Chlamydia among all symptomatic patients, those identified as being contacts of a known case, and those for whom history indicates a risk of exposure. In 2008, ADH detected about three times as many females with Chlamydia through family planning and maternity clinics as compared to the number detected through ADH STD clinics. This phenomenon relates to the greater amount of testing through the former programs, as well as to the often asymptomatic nature of the infection in females.

Continued adherence to national guidelines will be critical in controlling the spread of genital Chlamydia infections. However, expanded screening and treatment, as resources allow, must also be considered in light of the recently observed increase in frequency. //2010//

Health Status Indicators 06A: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and race. (Demographics)*

HSI #06A - Demographics (TOTAL POPULATION)

CATEGORY TOTAL POPULATION BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	40870	30754	9075	420	621	0	0	0
Children 1 through 4	158107	121685	32038	1698	2686	0	0	0
Children 5 through 9	190877	146502	39508	2066	2801	0	0	0
Children 10 through 14	189588	145230	40013	1818	2527	0	0	0
Children 15 through 19	197560	150984	42340	2010	2226	0	0	0
Children 20 through 24	187407	144335	38755	2057	2260	0	0	0
Children 0 through 24	964409	739490	201729	10069	13121	0	0	0

Notes - 2010
Data source: US Census Bureau, 2007 population estimates 0 to 1 year of age.

Please note: US Census Bureau includes Asian and Pacific Islander in the 'Asian' population estimate category.

Data source: US Census Bureau, 2007 population estimates 1 through 4 years of age.

Please note: US Census Bureau includes Asian and Pacific Islander in the 'Asian' population estimate category.

Data source: US Census Bureau, 2007 population estimates 5 through 9 years of age.

Please note: US Census Bureau includes Asian and Pacific Islander in the 'Asian' population estimate category.

Data source: US Census Bureau, 2007 population estimates 10 through 14 years of age.

Please note: US Census Bureau includes Asian and Pacific Islander in the 'Asian' population estimate category.

Data source: US Census Bureau, 2007 population estimates 15 through 19 years of age.

Please note: US Census Bureau includes Asian and Pacific Islander in the 'Asian' population estimate category.

Data source: US Census Bureau, 2007 population estimates 20 through 24 years of age.

Please note: US Census Bureau includes Asian and Pacific Islander in the 'Asian' population estimate category.

Narrative:
/2010/ Infants and children 0-4 represent the largest 5-year age group in Arkansas, reflecting the recent rise in births in the state. The next biggest group is 15-19 year olds, presumably due to a higher rate of in-migration in that age group (possibly related to college enrollment). Otherwise, relative frequencies of Whites, African Americans, Native Americans, and Asians have not varied much over the past several years. The biggest demographic shift over the past several years has been the rise in the Hispanic population (see HSI 06B). A numerically smaller phenomenon has been the influx of people from the Marshall Islands, whose total numbers in the northwest part of the state may range from 5,000 to 10,000. This sub-population has presented huge challenges in terms of communication and cultural barriers for Health Department staff in family planning and prenatal clinic settings, as well as during communicable disease outbreaks. The Marshallese have higher rates of poverty, higher infectious disease rates (perinatal Hepatitis B, TB, syphilis, HIV, Hansen's disease), and lower utilization of prenatal care than other immigrant and minority populations in the state. //2010//

Health Status Indicators 06B: *Infants and children aged 0 through 24 years enumerated by sub-populations of age group and Hispanic ethnicity. (Demographics)*

HSI #06B - Demographics (TOTAL POPULATION)

CATEGORY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
TOTAL POPULATION BY HISPANIC ETHNICITY			

Infants 0 to 1	36383	4487	0
Children 1 through 4	141337	16770	0
Children 5 through 9	174082	16795	0
Children 10 through 14	175544	14044	0
Children 15 through 19	186334	11226	0
Children 20 through 24	175948	11459	0
Children 0 through 24	889628	74781	0

Notes - 2010
Data source: US Census Bureau, 2007 population estimates 0 to 1 year of age.

Please note: US Census Bureau includes Asian and Pacific Islander in the 'Asian' population estimate category.

Data source: US Census Bureau, 2007 population estimates 1 through 4 years of age.

Please note: US Census Bureau includes Asian and Pacific Islander in the 'Asian' population estimate category.

Data source: US Census Bureau, 2007 population estimates 5 through 9 years of age.

Please note: US Census Bureau includes Asian and Pacific Islander in the 'Asian' population estimate category.

Data source: US Census Bureau, 2007 population estimates 10 through 14 years of age.

Please note: US Census Bureau includes Asian and Pacific Islander in the 'Asian' population estimate category.

Data source: US Census Bureau, 2007 population estimates 15 through 19 years of age.

Please note: US Census Bureau includes Asian and Pacific Islander in the 'Asian' population estimate category.

Data source: US Census Bureau, 2007 population estimates 20 through 24 years of age.

Please note: US Census Bureau includes Asian and Pacific Islander in the 'Asian' population estimate category.

Narrative:
/2010/ The Hispanic population continues to grow rapidly in Arkansas, accounting for 11% of infants and almost 8% of all residents less than 25 years old. Besides the obvious issues involved in reaching this group such as language barriers, cultural differences, and, in some cases, immigration status, special health concerns also reside within this group. Stresses related to acculturation, such as learning a new language, gaining and maintaining employment, discrimination, social isolation, and other adaptations to American society probably contibute to development of chronic disease in this population. Young Hispanic males in Arkansas, for example, are at high risk for obesity, with its attendant risks of diabetes mellitus, hypertension, and cancer. The Family Health Branch will continue systemic efforts to include planning for Latino populations through all its programs. //2010//

Health Status Indicators 07A: *Live births to women (of all ages) enumerated by maternal age and race. (Demographics)*

HSI #07A - Demographics (Total live births)

CATEGORY Total live births	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Women < 15	76	28	43	0	0	0	0	5
Women 15 through 17	1780	1115	576	16	1	5	0	67
Women 18 through 19	4135	2844	1111	36	1	21	0	122
Women 20 through 34	31307	23736	5818	185	123	410	0	1035
Women 35 or older	3181	2500	437	16	33	68	0	127
Women of all ages	40479	30223	7985	253	158	504	0	1356

Notes - 2010
Data source: 2008 birth certificates, Health Statistics Branch, ADH.

Data source: 2008 birth certificates, Health Statistics Branch, ADH.

Data source: 2008 birth certificates, Health Statistics Branch, ADH.

Data source: 2008 birth certificates, Health Statistics Branch, ADH.

Data source: 2008 birth certificates, Health Statistics Branch, ADH.

Narrative:
/2010/ Total births have trended upward over the past five years (2003-2008). Births in all race categories have risen, but as mentioned in HSI 06A, one of the most interesting phenomena involves the influx of Marshallese into the northwest corner of the state. Many of the 504 Pacific Islander/Hawaiian origin births recorded (provisionally) in 2008 above are from this sub-population. This group of people continues to pose particular challenges as a result of communication and cultural barriers.

With regard to age, births to young women less than 15 years old remain a particular concern. The largest overall rise in births has been in the 20-24 year age group, however. Comparing demographic subgroups, there is numerical evidence of differences in peak maternal age, with African Americans have the earliest peak and Asians the latest peak. These differences parallel disparities in infant mortality. //2010//

Health Status Indicators 07B: *Live births to women (of all ages) enumerated by maternal age and Hispanic ethnicity. (Demographics)*

HSI #07B - Demographics (Total live births)

CATEGORY Total live births	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Women < 15	61	15	0

Women 15 through 17	1566	202	12
Women 18 through 19	3777	348	10
Women 20 through 34	27961	3283	63
Women 35 or older	2705	466	10
Women of all ages	36070	4314	95

Notes - 2010
Data source: 2008 birth certificates, Health Statistics Branch, ADH.

Data source: 2008 birth certificates, Health Statistics Branch, ADH.

Data source: 2008 birth certificates, Health Statistics Branch, ADH.

Data source: 2008 birth certificates, Health Statistics Branch, ADH.

Data source: 2008 birth certificates, Health Statistics Branch, ADH.

Narrative:
/2010/ As indicated elsewhere, births to Hispanic women have increased over the past several years, and now account for almost 11% of births in Arkansas. While the proportion of births to Hispanic women that occur at 17 years or less is similar to that for non-Hispanic women, the proportion of births that occur at 18-19 years of age is slightly lower for Hispanic (8%) than for non-Hispanic (10.5%) women. However, many Hispanic women in Arkansas are first-generation, and it is well known that many "protective" effects seen within an acculturating population tend to wane over the first 10-20 years.

The ADH Center for Local Public Health, working in conjunction with Family Health and other programs, has made great strides in addressing the needs of the growing Hispanic population in Arkansas. Spanish-language interpreters are available in most local health units, and written materials in Spanish are available for prenatal and family planning patients. Further efforts to achieve true cultural competence and effectiveness in all clinics in every health unit are ongoing. //2010//

Health Status Indicators 08A: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and race. (Demographics)*

HSI #08A - Demographics (Total deaths)

CATEGORY Total deaths	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**
Infants 0 to 1	291	176	102	1	0	0	0	12
Children 1 through 4	64	40	16	0	1	0	0	7
Children 5 through 9	36	26	9	0	0	0	0	1
Children 10 through 14	32	25	7	0	0	0	0	0
Children 15	191	147	35	0	0	1	0	8

through 19								
Children 20 through 24	234	175	42	3	2	0	0	12
Children 0 through 24	848	589	211	4	3	1	0	40

Notes - 2010
Data source: Provisional 2008 death certificate data, Health Statistics Branch, ADH.

Data source: Provisional 2008 death certificate data, Health Statistics Branch, ADH.

Data source: Provisional 2008 death certificate data, Health Statistics Branch, ADH.

Data source: Provisional 2008 death certificate data, Health Statistics Branch, ADH.

Data source: Provisional 2008 death certificate data, Health Statistics Branch, ADH.

Data source: Provisional 2008 death certificate data, Health Statistics Branch, ADH.

Narrative:
/2010/ Deaths to children are most concentrated in the period of infancy, where prematurity/perinatal conditions, congenital anomalies, and SIDS take a large toll. African American infants in Arkansas die at a disparately high rate, for reasons that are undoubtedly preventable to some extent. The next spike in mortality occurs in older adolescents and young adults. Many of these deaths are due to injury, both unintentional and intentional, and are therefore preventable as well. //2010//

Health Status Indicators 08B: *Deaths of infants and children aged 0 through 24 years enumerated by age subgroup and Hispanic ethnicity. (Demographics)*

HSI #08B - Demographics (Total deaths)

CATEGORY Total deaths	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**
Infants 0 to 1	269	18	4
Children 1 through 4	54	10	0
Children 5 through 9	34	2	0
Children 10 through 14	32	0	0
Children 15 through 19	179	11	1
Children 20 through 24	222	12	0
Children 0 through 24	790	53	5

Notes - 2010
Data source: Provisional 2008 death certificate data, Health Statistics Branch, ADH.

Data source: Provisional 2008 death certificate data, Health Statistics Branch, ADH.

Data source: Provisional 2008 death certificate data, Health Statistics Branch, ADH.

Data source: Provisional 2008 death certificate data, Health Statistics Branch, ADH.

Data source: Provisional 2008 death certificate data, Health Statistics Branch, ADH.

Data source: Provisional 2008 death certificate data, Health Statistics Branch, ADH.

Narrative:
/2010/ Hispanic infants in Arkansas have to date had infant mortality rates lower than African Americans and similar to those of Whites, but experience elsewhere suggests this protective effect may well disappear over the next several years. Numbers of deaths in other age categories are small, perhaps too small to draw any inferences from. //2010//

Health Status Indicators 09A: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by race. (Demographics)*

HSI #09A - Demographics (Miscellaneous Data)

CATEGORY Misc Data BY RACE	**Total All Races**	**White**	**Black or African American**	**American Indian or Native Alaskan**	**Asian**	**Native Hawaiian or Other Pacific Islander**	**More than one race reported**	**Other and Unknown**	**Specific Reporting Year**
All children 0 through 19	3004	1000	1000	1	1	1	1	1000	2008
Percent in household headed by single parent	100.0	0.0	0.0	0.0	0.0	0.0	0.0	100.0	2008
Percent in TANF (Grant) families	100.0	0.0	0.0	0.0	0.0	0.0	0.0	100.0	2008
Number enrolled in Medicaid	100	0	0	0	0	0	0	100	2008
Number enrolled in SCHIP	100	0	0	0	0	0	0	100	2008
Number living in foster home care	100	0	0	0	0	0	0	100	2008
Number enrolled in food stamp program	100	0	0	0	0	0	0	100	2008
Number enrolled in WIC	100	0	0	0	0	0	0	100	2008
Rate (per 100,000) of juvenile crime arrests	100.0	0.0	0.0	0.0	0.0	0.0	0.0	100.0	2008
Percentage of high school drop-outs (grade 9 through 12)	100.0	0.0	0.0	0.0	0.0	0.0	0.0	100.0	2008

Notes - 2010

Narrative:
/2010/ The Family Health Branch attempted to gather data to complete this table for the year 2008. However, numerous barriers were encountered this year, including major difficulties accessing Medicaid and other DHS programs data. The Branch will make a concerted effort to provide all of these data as part of next year's application in conjunction with the five-year needs assessment. //2010//

Health Status Indicators 09B: *Infants and children aged 0 through 19 years in miscellaneous situations or enrolled in various State programs enumerated by Hispanic ethnicity. (Demographics)*

HSI #09B - Demographics (Miscellaneous Data)

CATEGORY Miscellaneous Data BY HISPANIC ETHNICITY	**Total NOT Hispanic or Latino**	**Total Hispanic or Latino**	**Ethnicity Not Reported**	**Specific Reporting Year**
All children 0 through 19	0	0	100	2008
Percent in household headed by single parent	0.0	0.0	100.0	2008
Percent in TANF (Grant) families	0.0	0.0	100.0	2008
Number enrolled in Medicaid	0	0	100	2008
Number enrolled in SCHIP	0	0	100	2008
Number living in foster home care	0	0	100	2008
Number enrolled in food stamp program	0	0	100	2008
Number enrolled in WIC	0	0	100	2008
Rate (per 100,000) of juvenile crime arrests	0.0	0.0	100.0	2008
Percentage of high school drop-outs (grade 9 through 12)	0.0	0.0	100.0	2008

Notes - 2010

Narrative:
/2010/ The Family Health Branch attempted to gather data to complete this table for the year 2008. However, numerous barriers were encountered this year, including major difficulties accessing Medicaid and other DHS programs data. The Branch will make a concerted effort to provide all of these data as part of next year's application in conjunction with the five-year needs assessment. //2010//

Health Status Indicators 10: *Geographic living area for all children aged 0 through 19 years.*

HSI #10 - Demographics (Geographic Living Area)

Geographic Living Area	**Total**
Living in metropolitan areas	0
Living in urban areas	460688
Living in rural areas	316314
Living in frontier areas	0
Total - all children 0 through 19	777002

Notes - 2010

Narrative:
/2010/ A general trend toward migration largely to larger towns and cities has continued in Arkansas, with the exception of growth of certain suburban communities. According to US Census data, the fastest growing part of the state in SFY08 was the northwest corner (Washington, Benton, Madison Counties), followed by the counties surrounding Little Rock in central Arkansas (Pulaski, Faulkner, Saline, Perry, Garland, Lonoke, Grant). Craighead and Poinsett Counties (near Jonesboro in northeast Arkansas), White County (Searcy), and Miller County (Texarkana) also displayed moderate growth, along with Pope (Russellville) and Yell Counties. A decrease in population (out-migration) was observed in Jefferson (Pine Bluff), Lincoln, and Cleveland Counties, along with numerous counties in the southwestern portion of the state. These overall population trends are important to track for program planning purposes. //2010//

Health Status Indicators 11: *Percent of the State population at various levels of the federal poverty level.*

HSI #11 - Demographics (Poverty Levels)

Poverty Levels	Total
Total Population	2802671.0
Percent Below: 50% of poverty	4.4
100% of poverty	13.8
200% of poverty	38.2

Notes - 2010
Data source: US Census Bureau, Current Population Survey, Annual Social and Economic Suppplement, 2008.

Data source: US Census Bureau, Current Population Survey, Annual Social and Economic Suppplement, 2008.

Data source: US Census Bureau, Current Population Survey, Annual Social and Economic Suppplement, 2008.

Data source: US Census Bureau, Current Population Survey, Annual Social and Economic Suppplement, 2008.

Narrative:
/2010/ The estimate for Arkansans at less than 50% of poverty is actually similar to a recent estimate from the Census Bureau for the entire US population, while the figure for those at less than 200% FPL in Arkansas remains substantially higher than that for the US (about 30% in 2007). The latter difference obviously reflects lower average incomes for working Arkansans. Socioeconomic status has major implications for health in a population. Many groups in Arkansas have partnered to promote economic development, including private business, the Governor's Office, state agencies and commissions, higher education, and many others. The Title V program has worked with many such groups at various times on projects related to education, social services, and youth development, all of which are key to improving longterm outcomes in the state.

Poverty percentages are also important determinants of eligibility for federal and state programs. Recently passed legislation enabling Medicaid coverage for children and pregnant women up to 250% of poverty is a major step forward for Arkansas. //2010//

Health Status Indicators 12: *Percent of the State population aged 0 through 19 years at various levels of the federal poverty level.*

HSI #12 - Demographics (Poverty Levels)

Poverty Levels	Total
Children 0 through 19 years old	782802.0
Percent Below: 50% of poverty	6.3
100% of poverty	19.1
200% of poverty	51.9

Notes - 2010
Data source: US Census Bureau, Current Population Survey, Annual Social and Economic Suppplement, 2008.

Data source: US Census Bureau, Current Population Survey, Annual Social and Economic Suppplement, 2008.

Data source: US Census Bureau, Current Population Survey, Annual Social and Economic Suppplement, 2008.

Data source: US Census Bureau, Current Population Survey, Annual Social and Economic Supplement, 2008.

Narrative:
/2010/ While similar to national estimates for the <50% and <100% FPL ranges, Arkansas is substantially above the US proportion (39%) of children 0-18 at less than 200% FPL. Children in lower income levels are at higher risk for many acute and chronic diseases, environmental exposures, and developmental and socio-emotional problems. Fortunately, recently enacted expansion of Medicaid eligibility to 250% FPL in the state will allow health coverage for some children not currently eligible, and encourage enrollment for many others who are already eligible. Apart from working with advocacy groups to support provision of basic health insurance, Title V program staff also oversee Health Connections activities to link children with Medicaid PCP's and dentists, and encourage routine physician/dental visits. Program staff also work regularly with staff from other branches, centers, and state agencies in support of initiatives targeting lower income children such as immunization outreach, WIC, lead exposure, and infant mortality reduction. //2010//

F. Other Program Activities

Other program activities relevant to women and children include Breast and Cervical Cancer Control, Diabetes Prevention and Control, Cardiovascular Health, and the Tobacco Prevention and Education Program. These programs are located in the Chronic Diseased Branch, also within the Center for Health Advancement.

The purpose of the Breast and Cervical Cancer Control Program (BreastCare) is to reduce morbidity by increasing the rate of early detection of breast and cervical cancer through education, screening, diagnosis and treatment of women in Arkansas.

Target Population
BreastCare continues to focus screening efforts on women 40 years old and older throughout

Arkansas that are uninsured or underinsured and have rarely or never been screened for breast and cervical cancer and on women in special populations.

Description of Services

-The BreastCare Program's goals and activities include the following:
·To provide education to the public about the importance of breast and cervical screening. BreastCare is currently providing mini-grant funding to a total of 14 community and faith-based organizations for activities that promote outreach and educational efforts.
·To create statewide partnerships to promote collaboration and provide navigation through the medical system. BreastCare is collaborating with partners such as YWCA EncorePlus and The Witness Project to reduce barriers to screening services and to navigate patients through the system.
To increase enrollment in the BreastCare Program by increasing the availability of free screening and follow-up services to uninsured and underinsured women.

- Comprehensive Cancer Control Program is to provide a framework for action to reduce the burden of cancer in Arkansas.

Target Population:The Comprehensive Cancer Control Program targets: 1) underserved residents of the state, 2) decision-makers and health policy-makers, 3) youth of Arkansas.

Description of Services: The Comprehensive Cancer Control Program coordinates planning and implementation of a broad array of partner activities in the following areas:
·Public education and prevention
·Early detection, treatment and support
·Professional education and practice
·Evaluation

The purpose of the Diabetes Prevention and Control Program (DPCP) is to reduce the burden of diabetes and its complications in Arkansas.

Target Population:Persons at risk for diabetes statewide.

Description of Services:
·Collects, analyzes, and distributes data on diabetes;
·Establishes and maintains a statewide diabetes coalition;
·Develops and promotes public education awareness campaigns;
·Creates and distributes educational materials for all diabetes populations;
·Develops outreach programs for minority populations;
·Partners with public and private organizations to increase the number of ADA recognized diabetes education programs in the state;
·Participates in a statewide diabetes collaborative based on the chronic care model;
·Provides community, organization project kits and assists in implementation of interventions related to diabetes such as the Lower Extremity Amputation Prevention program implemented through Hometown Health Coalitions.

The purpose of the CVH Program is to develop a state plan to reduce the burden of cardiovascular disease (CVD).

Target Population:All Arkansans.

Description of Services: The goals of the program are to:
·Improve cardiovascular health of all Americans
·Reduce disparities
·Delay onset of disease

·Postpone death
·Reduce disabling conditions

To achieve these goals, the CVH Program:
·Facilitates the CVH Program's Task Force in developing a state plan
·Developed a report on the Burden of CVD in Arkansas, "Mortality, Cost, Disparity, and Risk Factors;"
·Contracts for surveys to help define the burden of disease in Arkansas:
A work site survey
A chart review health site survey
A seven-county Delta survey
·Partners with the Arkansas Wellness Coalition -- a collaboration of public and private sector health organizations and networks to provide American Heart Association and CVH guidelines and tools to physicians within the State
.Collaborates with the Community Health Centers of Arkansas, Inc. (CHCs) to spread the Chronic Disease Collaborative Model for Cardiovascular and Diabetes within the CHC and other systems.

The purpose of the Tobacco Prevention and Education Program (TPEP) is:
·To reduce disease, disability and death related to tobacco by preventing the initiation of tobacco use among young people;
·Promote quitting among young people and adults;
·Eliminate exposure to second-hand smoke and identifying and eliminating the disparities related to tobacco use and its effects on population groups.

Target Population:All Arkansans with particular attention to preventing the initiation of tobacco use among youth and promoting quitting among tobacco users.

Description of Services:Community Programs: Grants have been awarded to 49 communities to build coalitions with diverse partners; create tobacco-free environments; reduce youth access; decrease advertising and promotion of tobacco products and promote the use of cessation resources.

//2006// Other new activities that will impact on the MCH Programs relate to the development of a whole new Branch as part of the Center for Health Advancement. Called the LifeStage/HealthyArkansas Branch, this unit will be hiring staff in three population areas and three skill areas. The areas addressing broad populations, each as a group include Children in Schools, Adults in the Workplace, and the Elderly. The areas addressing skills include Physical Activity, Nutrition, and Tobacco Cessation. These new staff will be well trained public health leaders who will become knowledgeable each in his own area relative, not only to the science base in the area, but also the community based issues and activities.

//2008// Family Health is encouraging all Branches of the Center for Health Advancement to do some common strategic planning. All Branches have interests in activities regarding public awareness, social marketing, patient education and professional education. It is apparent that funds from all Branches could be coordinated to build capacity within the Center enhance operations of these kinds. With this in mind, and thinking forward to the next five-year MCH Block Grant cycle, it has been suggested that the Center for Health Advancement design a collaborative needs assessment for the health of women and children in Arkansas, following which coordinated approaches involving all Branches could be devised to be implemented in the MCH Block Grant Application submitted in 2009 for FFY 2010. //2008//

//2010// Coordination with chronic disease programs is gradually being enhanced. //2010//

G. Technical Assistance

The Arkansas Division of Health, Women's Health Work Unit, requests assistance for a prenatal services assessment. The assessment would include evaluations and recommendations for improvement in the clinical services, patient flow, also client and colleague satisfaction. An independent consultant firm would be utilized to provide this operational analysis and assessment. The chosen firm would provide recommendations to improve operational processes: thereby giving suggested means for measurable improvements in prenatal care services provided by our agency.

Assistance is requested on the best techniques to use in forming a MCH partnership among multiple agencies to increase the quantity and quality of public input and participation in issues around MCH. The UAMS College of Public Health through student preceptorships and integration projects would provide technical assistance.

//2007// The Family Health Branch requests assistance in identifying ways to address lead screenings in Arkansas. Our problem is a systems problem, i.e., linking WIC, private providers, Medicaid, and the appropriate laboratory. A CDC consultant could be utilized to help us address our lead screening needs. //2007//

//2008// The Title V CSHCN program requests technical assistance in the area of methods to hire more parents of CSHCN, whether by contract or sub-grant, including how to write the contract/sub-grant and methods of monitoring. The Title V CSHCN program does not have experience within the leadership in the area of contracts. //2008//

//2008// Given that Medicaid earnings for prenatal care have been level and not increasing, and that state agency budgets remain stretched to continue the basic programs, the Family Health Branch would like to consider implementing a fee for prenatal care. The fee would be discounted for families under 200% of poverty and no cost for those under 100% of poverty. It would be set up in a well published policy and local health unit patients would be informed. No patient would be denied services based on ability to pay. Technical assistance with the process of determining the true cost of providing the services is desired.//2008//

//2008// As the Family Health Branch looks forward to initiating a new five year plan to be implemented starting in July 2009, advance work must be done to conduct the required needs assessment, and develop a subsequent implementation plan. We envision a stage in which stakeholders will be brought together, first within the ADH, and subsequently from among our external planning partners, to establish priorities. We would like these stakeholder discussions, once priorities are being advanced for selection, to be informed by the latest scientific evidence regarding "best practice" interventions that might be employed. A technical assistance effort devoted both to guiding effective stakeholder input, and to selecting best practice interventions would be very helpful. These could take place either in FY 2008 or 2009, or both. //2008//

//2010// Although Arkansas envisioned needing TA for facilitation of stakeholders' meetings, staff was able to provide this leadership, and the May 13th Stakeholders' meeting was successful. Family Health Branch's Block Grant Leadership Team continues to be interested in future application of needs assessment techniques such as focus groups, surveys, key informant interviews, Study Circles, and others. Last year, the unfolding of the Natural Wonders Partnership's needs assessment process has performed all of these functions, informing our planners of the major concerns throughout the state for children's health systems. The May 13th Stakeholders meeting, coming just after publication of the 2008 report of Natural Wonders, served to update and bring additional attention to some focus areas. New emphasis on lifestyle change and behavioral interventions occurred. With the passage of the new tobacco tax, several major concerns raised by Natural Wonders have begun to be addressed. These include expansion of Medicaid eligibility in AR Kids A and B to 250% of poverty and continuing attention to adequate reimbursement levels in Medicaid. Access to quality health care for children is being addressed through efforts to bring primary care physician (PCP) practices into

consistency with the concepts of the Medical Home. Medicaid is working with 40-50 PCP practices as EPSDT pilots, and has piloted the use of the Ages and Stages Questionnaire (a validated developmental assessment tool) in an urban pediatric and a small town family medicine practice. //2010//

//2010// Drs. Margaret Caughy and Gwendolyn Adam at Baylor School of Medicine, working with the University of Texas School of Public Health have applied for and received funding from the MCH Bureau for multi-modal and distance education for MCH professionals. While students may not be incorporated into this program until early in 2010, the future is open to involving those students in TA assignments like focus groups, key informant interviews, surveys and Study Circles. As Arkansas begins to clarify its intentions regarding interventions to reduce infant mortality, students may also be of assistance in reviewing the community evidence base for effectiveness. //2010//

V. Budget Narrative

A. Expenditures

/2006/ Total Expenditures for the FY2004 Federal-State MCH Partnership were $25,262,986 a substantial decline from the amount budgeted, $33,831,514, for FY2004, or expended the previous year $31,078,443. Expenditures at ADH dropped as reductions in direct services occurred. This was particularly apparent with MCH Block funds, as provision of maternity care was reduced. As direct services declined, Medicaid revenues declined proportionally. These declines resulted in the reduction of 123 positions throughout ADH, the actual lay-off of 38 employees, and reassignment of 11.

The state match contribution of $18,362,351 more than met the maintenance of effort requirement of $5,797,136. Much of the ADH's state contribution has been documented through time-allocation. In July 2001, the Arkansas Administrative Statewide Information System, an integrated accounting, human resources, and materials management System provided a modern, automated accrual accounting system across all state agencies. The system was implemented without a cost-allocation system. Consequently, state effort from time allocation in this application is based on 2001 figures, which have been adjusted for changes in clinic activity and increases in salary. This situation should be rectified by July 2005 as a cost allocation system compatible with AASIS is currently under development. A new e-mail-based random moment time allocation system was implemented July 1, 2005. Data from this system will be available for FFY 2006 to document the state effort provided.

Expenditures of program income of $13,089,886 were less than the $17,486,955 budgeted. This decrease included declines in ADH clinical activity and income from case management performed by CMS.
ADH has made a concerted effort to redefine budget to distinguish direct services from enabling services and population-based services. Also, numbers are affected by caseload declines across programs in FY 2003. Movement of state match away from well-child clinics to immunization clinics moved nearly $3 million in expenditures from direct services to population-based services.

ADH identified expenditures for health education and other enabling services that had previously been counted as direct services. This included surveying staff regarding the amount of time expended in family planning and maternity offices visits that was directed toward health education and other enabling services, as opposed to the direct provision of health care services. This moved about one-third of staff time for family planning and about forty percent of staff time for maternity to enabling.

The CSHCN budget for FFY 2004 reflects a difference of $4.3 million dollars between the 2004 budgeted and expenditure amounts. Budgeted program income for FFY 2004 was $2.5 million in case management revenue from Medicaid. Actual income received for case management billing during that time period was $1.4 million. Total expenditures in FFY 2004 for Children's Services was $4.07 million, which was a decrease of $3.28 million from expenditures in FFY 2003. This decrease is attributed to a change in eligibility criteria established in earlier years. Financial eligibility criteria decreased to 185% of Federal Poverty Level and age eligibility criteria was changed from age 21 years to age 18 years. These changes coupled with an ongoing problem with issuing payments via electronic means resulted in the decreased spending. Decreased program income plus decreased spending equals the variance from the planned budget.

//2007// Total Expenditures for the FY 2005 Federal-State MCH Partnerships were $24,442,925, a substantial decline from the amount budgeted, $30,421,208, for FY 2005, or expended the previous year - $25,262,986. Expenditures at the Department of Health and Human Services-Division of Health dropped as reductions in direct services occurred. This was particularly

apparent with MCH Block Funds, as provision of maternity care was reduced. As direct services declined, Medicaid revenues declined proportionally.

The total state match contribution of $21,211,514, more than met the Maintenance of Effort requirement of $5,797,137. The Division of Health's contribution is $17,225,686. The Department of Health and Human Services is working toward incorporation of Division of Health operations into the agency's cost allocation plan. An automated random moment time study process for county nurses and clerical staff is currently in development, which will be used to provide documentation and support in a cost allocation plan amendment. The amendment will be submitted to the Dallas Regional Office of Health and Human Services, Division of Cost Allocation asking for an effective forward activity date of July 1, 2007 as part of a Division of Health package. This date coincides with the finalization of single agency business area financial reporting. Approval documentation will be provided to USDA following DCA approval.

Expenditures of program income of $12,264,962 were less than the $15,264,743 budgeted. This decrease included declines in Division of Health's clinical activity. //2007//

//2008// Total Expdenditures for FY 2006 Federal-State title V Block Grant Partnership totaled $32,493,293 an increase from last year and much closer to the amount budgeted of $30,806,594. Expenditures at the Department of Health and Human Services rose as costs rose. This was especially evident in the cost of salaries, as a new salary structure was introduced to make nurse salaries more competitive with the private sector. Besides the additional cost increase per nurse, the Division was successful in decreasing the number of unfilled nursing positions, due to the increase in pay. This also increased the amount of money spent on salaries.

The total state match contribution of $21,286,889 more than met the Maintenance of Effort requirement of $5,797,136.

For state fiscal year 2007-08, the Arkansas Department of Health is under an approved Indirect Cost Rate. For the preceeding two state fiscal years, as a division of the Arkansas Department of Health and Human Services (DHHS), a cost allocation plan was developed and submitted to HHS Division of Cost Allocation in Dallas, but not yet approved, under 2 CFR Part 225 Appendix D Public Assistance Cost Allocation Plans. As a stand-alone public health agency, ADH cost allocation requirements align with 2 CFR Part 225 Appendix E State and Local Indirect Cost Rate Proposals. We are working to develop a new indirect cost rate based on direct salaries to submit to HHS Division of Cost Allocation in Dallas. //2008//

/2009/ The total expenditures for fy 2007 Federal-State Title V Block Grant Partnership totaled $33,366,269, an increase from last year. Expenditures rose due to salary increases, supply cost increases, a new salary grid for nurses and consequently a decrease in unfilled positions at the Arkansas Department of Health. The family planning program and maternity program did see a reduction in patients resulting in some decrease in expeditures.

The Department of Human Services' Children with Special Health Care Needs (CSHCN) program used Title V carryover funds from FFY 06 (Oct 1 2006 through Sept 2007) during the FFY 07 for payment of medical expenses for non-Medicaid clients, purchase of items not covered by Medicaid that ease the physical burden of caring for CSHCN in the home and for continuation of the Title V Family Support/ Respit program.

For state fiscal year 2007-08, the Arkansas Department of Health is under an approved Indirect Cost Rate. For the preceeding two state fiscal years, as a division of the Arkansas Department of Health and Human Services (DHHS), a cost allocation plan was developed and submitted to HHS Division of Cost Allocation in Dallas, but not yet approved, under 2 CFR Part 225 Appendix D Public Assistance Cost Allocation Plans. As a stand-alone public health agency, ADH cost allocation requirements align with 2 CFR Part 225 Appendix E State and Local Indirect Cost Rate Proposals. ADH is working to develop a new indirect cost rate based on direct salaries to submit

to HHS Division of Cost Allocation in Dallas. ADH presently conducts a 100% survey of employees regarding how much time they are spending on activities that can be tied to specific funding streams. //2009//.

/2010/ Total Expenditures for the FFY 2008 ($32,921,020) Federal-State MCH Partnerships was a substantial increase from the FFY 2007. Expenditures at the Arkansas Department of Health and the Department of Human Services increased despite some decreases in state contributions. Fund balances were exhusted and additional fees were collected in order for the increase in expenditures to occur.

The total state match contribution of $20,686,682 more than met the Maintenance of Effort requirement of $5,797,136. The Arkansas Department of Health cost allocation plan is in its final stages and will take effect July 1, 2009. The plan requires every employee to represent time spent and on what activity.

Expenditures of program income of $15,785,615 were more than the $13,207,108 budgeted. Increased expenses for salary and fringe for clinic staff resulted in higher than projected costs. In addition the Expansion of our Newborn Screening Program contributed to expensis being higher than projected. This increase in cost was funded through the spending of the Mediciaid fund balances and increased fees for Newborn Screening.

Administrative costs for CSHCN were listed in the Children with Special Health Care Needs column previously in the MCH applications. This has been switched to the administrative cost column this year, to more accurately reflect how funds were spent. //2010//

B. Budget

After the budget shortfall ADH faced in state fiscal year 2005, the agency recovered somewhat in clinical efforts and income. Both maternity and immunization performance improved markedly and family planning stabilized. This was after the Department had experienced a 30 percent decline in clinical visits from 2001 to 2004. Overall clinical activity improved by 10.4% in 2004.

The projected Title V appropriation for Arkansas was estimated at $7,483,501. Preventive and Primary Care for Children is budgeted at $4,066,144 or 54.3% percent of the total. The amount projected for CSHCN (CMS) is $2,345,187, which is 31.34 percent of the total. Title V administrative costs are estimated at $428,392, 5.7% of the total allocation. The amount of total State funds budgeted is $7,003,381. The total state match is 22,251,115. Each of these budgeted items satisfies the legislative requirements. Total carryover projected from previous years is $1,071,978. The large amount of carry-over is the result of reductions in ADH clinical services and CMS case management services.

The MCH budget reflects expenditures budgeted on program income have stabilized since last year. The State MCH Budget Grand Total has increased to $111,266,765. Much of this increase was from federal funds, particularly, WIC.

$13,231,720 of the FY2006 ADH share of the Federal Sate Title V Block Grant Partnership Total will be expended for direct health care services. This reduction reflects both the actual declines in the provision of services and re-computation of the expenditure by type of service taking into account that immunization activity is counted as population based services, and re-categorizing some activities formerly counted as direct services more appropriately as enabling services. Also, much of the state match counted in previous years reflected effort in child health clinics and school health. This effort has been replaced by child immunization activity. The pyramid reflects that more MCH grant funds are now directed to the Hometown Health effort and building infrastructure in local communities.

The Title V Block Grant for CMS is projected to be $2,605,755 plus a carryover of $198,958 has

been estimated. The state funds to CMS totals $2,114,531.

Non-Federal Funding -- CMS receives full cost reimbursement from Medicaid for performing case management for Medicaid clients on the CMS program. This funding is estimated at $1,500,000 in FFY 2005. These funds are categorized as program income. Policy Development and Program Development and Management are included in the administration of Title V. Quality Assurance & Standards Development and Community Assessment are included in CSHCN Care Coordination.

CMS Administrative costs are budgeted at $2260,568 Title V and $97,976 state funds. The budget by types of service is estimated along with the breakdown of administrative costs for each of the four types of services.

//2007// The projected Title V appropriation for Arkansas was estimated at $7,191,246. Preventive and Primary Care for Children is budgeted at $3,672,379 or 51.0674 percent of the total. The amount projected for Children with Special Health Care Needs (CSHCN) is $2,253,593, which is 31.338 of the total. The Title V administrative costs are estimated at $476,589, 6.6273 percent of the total allocation. The amount of total State funds budgeted is $7,790,017. The total state match is $21,211,514. Each of these budgeted items satisfies the legislative requirements. Total carry forward projected from the previous year is $854,898 ($851,517-CMS; $3,381-DOH). CMS' increase in unobligated fund balance correlates to provider billings for direct medical services as well as normal variations between budget forecast and actual operations. The federal Title V funding carryforward will be expended in FFY 07. The state funds to CMS total $2,516,925 including $162,978 allocated to administrative costs. The remainder of the required state match is derived from expenditures on direct services and insurance collections. Without these insurance collections, CMS would have to pay more out of state funds to the hospital for direct medical services.

The MCH budget reflects a decrease in expenditures budgeted on program income since last year. The State MCH Budget Grant Total has decreased to $34,183,136. Much of this decrease is from Federal funds, particularly WIC, Injury Prevention, and Oral Health. These programs are no longer under the control of Richard Nugent, M.D., the person responsible for the administration of the Title V program.

$17,455,117 of the FY 2007 ADH share of the Federal-State Title V Block Grant Partnership Total will be expended for direct health care services. //2007//

//2007// Non-Federal Funding - CMS receives full cost reimbursement from Medicaid for performing case management for Medicaid clients on the CMS program. This funding is estimated at $1,468,903 in FYY 2007. These funds are categorized as program income. Policy Development and program Development and Management are included in the administration of Title V. Quality Assurance and Standards Development and Community are included in CSHCN Care Coordination.

Administrative costs are budgeted at $250,299 Title V and $162,978 state funds.

The budget by types of service is estimated along with the breakdown of administrative costs for each of the four types of services. //2007//

//2008// The projected Title V appropriation for Arkansas was again estimated at $7,191,246. Preventive and Primary Care for Children is budgeted at $4,266,223 or 59.33 percent of the total. The amount projected for Children with Special Health Care Needs (CSHCN) is $2,445,023, which is 34 percent of the total. The Title V administrative costs are estimated at $480,000, 6.67 percent of the total allocation. The amount of total State funds budgeted is $8,079,781. The total

state match is $21,286,889. Each of these budgeted items satisfies the legislative requirements.

The state funds to CSHCN totaled $2,526,242 including $166,922 allocated to administrative costs. The remainder of the required state match is derived from expenditures on direct services and insurance collections. without these insurance collections, CSHCN would have to pay more out of state funds to the hospital for direct medical services. CSHCN receives full cost reimbursement from Medicaid for performing case management for Medicaid clients on the CSHCN program. This funding is estimated at $1,624,854 in FFY 2008.

Policy Development and Program Development and Management are included in the administration of Title V. Quality Assurance and Standards Development and Community Assessment are included in the program partners making up the Title V Bock Grant.

$22,266,507 of the FY 2006 ADH share of the Federal-State Title V Block Grant Partnership Total was expended for direct health care services. //2008//

/2009/ The projected Title V appropriation for Arkansas was lowered to $7,066,705 to reflect reductions in funding during the present grant period. Preventive and Primary Care for Children is budgeted at $4,134,729 or 59.51 percent of the total. The amount projected for Children with Special Health Care Needs (CSHCN) is $2,460,627, which is 34.82 percent of the total. The Title V administrative costs are estimated at $471,349, 6.67 percent of the total allocation. The amount of total State funds budgeted is $3,149,026. The total state match is $16,201,750. Each of these budgeted items satisfies the legislative requirements.

The state funds projected to CSHCN total $1,729,279 including $126,537 allocated to administrative costs. The remainder of the required state match in CSHCN is derived from expenditures on direct services and insurance collections. Without these insurance collections, CSHCN would have to pay more out of state funds to the hospital for direct medical services. CSHCN receives full cost reimbursement from Medicaid for performing case management for Medicaid clients on the CSHCN program. This funding is estimated at $1,551,299 in FFY 2009.

Policy Development and Program Development and Management are included in the administration of Title V. Quality Assurance and Standards Development and Community Assessment are included in the program partners making up the Title V Bock Grant. //2009//

/2010/ Preventive and Primary Care for Children is budgeted at $4,134,729 or 60 percent of the total. The amount projected for Children with Special Health Care Needs (CSHCN) is $2,196,564, which is 30 percent of the total. The Title V administrative costs are estimated at $735,412, or 10% percent of the total allocation. The amount of total State funds budgeted is $4,530,304. This reflects state dollars directly budgeted in Arkansas Department of Health MCH programs and to the state effort through salaries paid from state general revenue that support MCH programs at the Arkansas Department of Health, captured in time allocation reports. Time allocation was not captured in the previous application. The total state match is $20,686,682. Each of these budgeted items satisfies the legislative requirements.

The state funds spent in CSHCN total $1,677,104 including $87,790 allocated to administrative costs. The remainder of the required state match in CSHCN is derived from expenditures on direct services and insurance collections. Without these insurance collections, CSHCN would have to pay more out of state funds to the hospital for direct medical services. CSHCN receives full cost reimbursement from Medicaid for performing case management for Medicaid clients on the CSHCN program. CSHCN program income for FFY 2008 fell below projections due to reduced reimbursements.

Policy Development and Program Development and Management are included in the

administration of Title V. Quality Assurance and Standards Development and Community Assessment are included in the program partners making up the Title V Block Grant. The Title V Block Grand funds provide an essential link between the programs in our state serving children and mothers. The funds provide a bridge between the Arkansas Department of Health and the Arkansas Department of Human Services, that creates a partnership resulting in better coordination and efficiency in serving the citizens of the state. It also serves as a platform from which new initiatives and partnerships outside of state government are made to tackle the health issues of the states children and women.//2010//

VI. Reporting Forms-General Information
Please refer to Forms 2-21, completed by the state as part of its online application.

VII. Performance and Outcome Measure Detail Sheets
For the National Performance Measures, detail sheets are provided as a part of the Guidance. States create one detail sheet for each state performance measure; to view these detail sheets please refer to Form 16 in the Forms section of the online application.

VIII. Glossary
A standard glossary is provided as a part of the Guidance; if the state has also provided a state-specific glossary, it will appear as an attachment to this section.

IX. Technical Note
Please refer to Section IX of the Guidance.

X. Appendices and State Supporting documents
A. Needs Assessment
Please refer to Section II attachments, if provided.

B. All Reporting Forms
Please refer to Forms 2-21 completed as part of the online application.

C. Organizational Charts and All Other State Supporting Documents
Please refer to Section III, C "Organizational Structure".

D. Annual Report Data
This requirement is fulfilled by the completion of the online narrative and forms; please refer to those sections.